Institut de recherche et documentation en économie de la santé

Les soins non programmés et le recours aux urgences hospitalières dans les pays de l'OCDE

Bibliographie thématique

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Sommaire

Définition et problématique

Les soins non programmés (unplanned care, urgent care) sont entendus "comme ceux devant répondre à une urgence ressentie, mais ne relevant pas médicalement de l'urgence et ne nécessitant pas une prise en charge par les services hospitaliers d'accueil des urgences"[1] La demande croissante en soins d'urgence ou urgence hospitalière est bien documentées dans la littérature scientifique. Elle génère dans les services d'urgence un accroissement des coûts et des temps d'attente ainsi qu'une pression sur les services concernés. Plusieurs facteurs sont mis en avant pour expliquer ce phénomène : le nombre croissant des personnes souffrant de maladies chroniques, le vieillissement de la population ainsi qu'un changement de comportement dans les modes de recours aux soins - les usagers privilégiant les dispositifs perçus comme les plus réactifs devant un besoin de soin inopiné.

En France, malgré les mesures entreprises depuis les années 1990 suite aux recommandations formulées dans le rapport Steg[2], dans les domaines de la sécurité des prises en charge de la médicalisation des urgences, des investissements hospitaliers, de l'organisation de la permanence des soins ambulatoires (PSDA), l'affluence dans les services d'urgence pour des soins non programmés est croissante alors que la proportion d'urgences graves reste stable[3]. Ainsi, en 2016, près de 21 millions de passages ont été recensés dans les 719 structures publiques et privées d'urgence, soit une progression de 2,5 % par rapport à 2015. Vingt ans auparavant, en 1996, le nombre de passages aux urgences s'établissait à 10 millions[4].

La question de l'accès aux soins dits « non programmés » était donc un des enjeux du plan national pour renforcer l'accès territorial aux soins, présenté le 13 octobre 2017 à Châlus (Haute-Vienne) par le Premier ministre et la ministre chargée de la santé avec 4 priorités : le renforcement de l'offre de soins dans les territoires au service des patients, une présence médicale et soignante accrue, la mise en œuvre de la révolution numérique en santé pour abolir les distances, une meilleure organisation

[1] Mesnier, T. (2018). Assurer le premier accès aux soins : organiser les soins non programmés dans les territoires. Paris Ministère chargé de la santé

[2] Steg, A. (1993). Rapport sur la médicalisation des urgences. Paris Ministère chargé de la santé

[3] Grall, J. Y. (2015). Rapport sur la territorialisation des activités d'urgences. Paris Ministère chargé de la Santé ; et Grall J.Y. (2016). Modalités de mise en œuvre du rapport sur la territorialisation des services d'urgence. Paris : Ministère chargé de la santé.

[4] Données de la Drees

des professionnels de santé pour assurer une présence soignante. Elle se trouve également au cœur de plusieurs chantiers de la Stratégie de transformation du système de santé lancée le 9 mars 2018 : « Qualité des soins et pertinence des actes », « Organisation territoriale », « Modes de financement et de régulation », « Numérique », « Ressources humaines et formation ».

L'objectif de cette bibliographie est de recenser de la littérature scientifique (articles, ouvrages, rapports, littérature grise…) sur les modes de recours aux soins non programmés ainsi que sur les motifs de la patientèle dans les pays de l'OCDE. Les recherches bibliographiques ont réalisées sur les bases et portails suivants Base de l'Irdes, Banque de données en santé publique (BDSP), Medline, Cairn, Science direct…. sur la période allant de 2000 à février 2020. Les notices bibliographiques sont classées par ordre d'alphabétique d'auteurs et de de titres. Cette bibliographie ne prétend pas à l'exhaustivité.

Soins non programmés : recours aux urgences hospitalières et structures alternatives

ÉTUDES FRANÇAISES

Assouvie, S., Criquet-Hayot, A., Tignac, S., et al. (2019). "La permanence des soins non programmés : place du médecin généraliste à la lumière d'une expérience en Martinique." Médecine : De La Médecine Factuelle à Nos Pratiques 15(4) : 178-185.

> Pourquoi les patients, en Martinique, privilégient-ils l'appel au centre 15 en journée pour les soins non programmés ? La régulation libérale est un acte médical, c'est la prise en charge des appels téléphoniques des patients ou de leurs proches pour une demande de soins non programmés. La régulation régionale de tous les appels urgents est assurée par le SAMU-Centre 15. Les médecins régulateurs hospitaliers du SAMU-Centre 15 de la Martinique allèguent un nombre important d'appels de médecine libérale en journée. Pour répondre à cette problématique, une phase d'expérimentation a été décidée par l'ARS pour étendre les plages de régulation libérale de 7 h à 17 h, hors permanence des soins ambulatoires libérale. L'objectif de notre étude est d'identifier les critères de choix qui conduisent les patients à privilégier l'appel au centre 15 en journée, dans le cadre des soins non programmés.

Baguet, F. (2017). "Les urgences hospitalières : Miroir des dysfonctionnements de notre système de santé." Gestions Hospitalières (570) : 555-557

> [BDSP. Notice produite par EHESP R0xHrAEJ. Diffusion soumise à autorisation]. En miroir du rapport sur la permanence des soins ambulatoires et en parallèle de celui de la Cour des comptes qui a mené en même temps que le Sénat des travaux sur l'organisation des urgences, trois sénateurs ont livré en juillet 2017 leurs vision et propositions sur l'organisation des urgences hospitalières. Conçu en exploitant des rapports publiés ces dernières années - enquête Drees 2013, auditions de personnalités qualifiées et visites d'établissements-le rapport adopte un point de vue centré sur les services d'urgence des hôpitaux. Ces derniers ressentent, d'après le rapport, une situation critique qu'ils subissent sans pouvoir en être acteurs. Le rapport invite à ne pas considérer les services d'urgence comme un point d'entrée défaillant dans le système de santé et à analyser leurs difficultés comme les conséquences d'une désorganisation globale de ce dernier. (R.A.).

Beaupin, A. (2013). "Demandes de soins non programmés et services d'urgences : le cas du projet du nouvel Hôtel-Dieu à Paris." Cahiers de Santé Publique et de Protection Sociale (Les) (10) : 19-23.

Roselyne Bachelot est entrée dans l'histoire pour sa gestion de la grippe en 2009 et ses fameux vaccinodromes. Le projet de consultodrome de l'Hôtel-Dieu hissera-t-il Marisol Touraine et Claude Evin au niveau de notoriété de Roselyne Bachelot ? Telle est la question abordée dans cet article.

Benevise, J.-F., Delaporte, S. et Becq-Giraudon, M. (2014). Évaluation de l'application du référentiel d'organisation du secours à personne et de l'aide médicale urgente. Rapport IGAS ; 2013 182. Paris IGAS
http://www.ladocumentationfrancaise.fr/rapports-publics/144000536-evaluation-de-l-application-du-referentiel-d-organisation-du-secours-a-personne-et-de

[BDSP. Notice produite par MIN-SANTE A89rsR0x. Diffusion soumise à autorisation]. Par lettre en date du 28 octobre 2013, la ministre des affaires sociales et de la santé et le ministre de l'intérieur ont demandé à l'inspection générale des affaires sociales (IGAS) et à l'inspection générale de l'administration (IGA) d'évaluer la mise en œuvre du référentiel d'organisation du secours à personne (SAP) et de l'aide médicale urgente (AMU) validé le 25 juin 2008 par la directrice de l'hospitalisation et de l'organisation des soins, le directeur de la défense et de la sécurité civile, les représentants des structures de médecine d'urgence et ceux des services d'incendie et de secours. Conformément à la lettre de mission, la présente évaluation porte à la fois sur l'effectivité de l'application du référentiel, sur l'efficacité de la réponse opérationnelle et sur l'efficience du dispositif aujourd'hui. La question de la pertinence du référentiel n'est pas traitée sur le plan des principes mais est abordée à travers l'approche globale de l'efficacité et de l'efficience atteintes. L'évaluation prend en compte l'existence d'un autre référentiel, publié presque concomitamment avec le premier et qui traite de l'organisation de la réponse ambulancière à l'urgence pré-hospitalière.

Bernstein, D. (2016). Avis sur les innovations et système de santé. Document 10 : L'hôpital de demain. Paris HCAAM.
https://www.securite-sociale.fr/files/live/sites/SSFR/files/medias/HCAAM/2015/ANNEXE/HCAAM-2015-RAPPORT-ANNEXE-L-HOPITAL_DE_DEMAIN.pdf

Trois contributions forment ce dossier : Perspective organisationnelle et technologique de l'hôpital (EHESP) ; Les plateaux techniques (contribution de l'ANAP) ; Penser l'hôpital de demain (contribution de Gérard de Pouvourville).

Blemont, P. et Favier, C. (2012). Permanences des soins et systèmes des urgences en France, Paris : Berger-Levrault

Ce livre fait le point sur les origines, les réformes nombreuses et importantes du service de permanence des soins et des urgences en France. Il décrypte les enjeux sous-jacents, propose une analyse critique des apports et carences de la loi HPST et formule des hypothèses d'évolution et de scenarii plausibles.

Boisguerin, B. et Valdelievre, H. (2014). "Urgences : la moitié des patients restent moins de deux heures, hormis ceux maintenus en observation." Etudes Et Résultats (Drees) (889)
https://www.data.gouv.fr/es/datasets/urgences-la-moitie-des-patients-restent-moins-de-deux-heures-hormis-ceux-maintenus-en-observation/

> [BDSP. Notice produite par MIN-SANTE A98R0xCl. Diffusion soumise à autorisation]. La prise en charge aux urgences dure moins de deux heures pour la moitié des patients si l'on exclut ceux ayant séjourné en unité d'hospitalisation de courte durée (UHCD). Dans 60% des cas, la venue dans un service d'urgences résulte de l'initiative du patient ou du conseil d'un proche. Deux patients sur trois viennent de leur domicile et sont arrivés majoritairement par leurs propres moyens. Ils sont moins souvent transportés par les sapeurs-pompiers ou par une ambulance. Le recours aux urgences est plus élevé pour les nourrissons et les personnes âgées de 75 ans ou plus et les motifs de recours sont aussi plus variés que pour les autres classes d'âges. Les lésions traumatiques constituent toujours la principale cause de venue aux urgences (36% des patients) et sont à l'origine de 7 passages sur 10 pour les 10-14 ans. Après un passage aux urgences, les 3/4 des patients rentrent chez eux et 20% sont hospitalisés.

Cash, E., Dupilet, C., Richard, T., et al. (2015). "Enquête qualitative préalable à la mise en place d'un dispositif statistique sur la mesure des délais d'attente dans l'accès aux soins." Série Etudes Et Recherches - Document De Travail (Drees) (133)

> [BDSP. Notice produite par MIN-SANTE nR0xIArn. Diffusion soumise à autorisation]. La problématique des délais d'accès aux soins ne met pas la France en mauvaise position dans les comparaisons internationales. Cette enquête montre qu'en dehors des cas urgents, dont la prise en charge est toujours assurée, il existe des délais parfois importants dans certains territoires déficitaires en professionnels de santé, concernant principalement l'ophtalmologie, la chirurgie dentaire, la psychiatrie, la cardiologie, l'endocrinologie et la gynécologie.

Chanteloup, M. (2000). "Les services d'aide médicale urgente (SAMU CENTRE 15), et les services mobiles d'urgence et de réanimation (SMUR) en 1998." Collection Etudes Et Statistiques (19)
https://www.amazon.fr/services-médicale-réanimation-Collection-statistiques/dp/B000WVBBP0

> L'enquête auprès des Samu (services d'aide médicale urgente)-centre 15 et des Smur (services mobiles d'urgence et de réanimation) a été lancée pour la première fois en 1988. L'enquête, annuelle, couvre l'ensemble des Samu et des Smur de France métropolitaine et des départements d'outre-mer. Mise en place à la demande de la Direction générale de la santé, elle recense les moyens existants dans le secteur de l'aide médicale urgente. Les données présentées portent sur l'activité en 1998.

Cohen, L., Genisson, C. et Savary, R. P. (2017). Les urgences hospitalières, miroir des dysfonctionnements de notre système de santé. Paris Sénat
http://www.senat.fr/rap/r16-685/r16-6851.pdf

> Face aux difficultés que rencontrent les services d'urgences hospitaliers, ce rapport formule vingt propositions concrètes, ancrées dans l'exercice quotidien des personnels, dans la perspective d'une mise en œuvre à court terme. Les rapporteurs proposent notamment, une amélioration du fonctionnement concret de ces services par une réforme de la tarification (modulation du montant du financement à l'activité en fonction de la gravité des pathologies et des actes réalisés, création d'un forfait de réorientation vers les structures de ville). Les autres propositions concernent les conditions de travail des équipes, les mesures incitatives pour la prise en charge des urgences légères par les médecins libéraux et la régulation médicale.

Collet, M. et Gouyon, M. (2007). "Genèse des recours urgents ou non programmés à la médecine générale." Etudes Et Résultats (Drees) (607)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er607.pdf

[BDSP. Notice produite par MIN-SANTE Eo0VbR0x. Diffusion soumise à autorisation]. Une grande partie de la demande de soins "en urgence" est prise en charge par la médecine générale de ville : en 2004, on estimait à 35 millions le nombre de recours urgents ou non programmés à la médecine générale de ville quand les services d'urgences des hôpitaux enregistraient 14 millions de passages. Une majorité d'usagers a tenté de se soigner seule ou déjà a consulté un médecin pour ce même problème et 42 % n'ont décidé de recourir en urgence ou à un généraliste que deux jours (ou plus) après les premiers symptômes.

Coppoletta, R. et Le Palud, V. (2014). "Qualité et accessibilité des soins de santé : qu'en pensent les Français ?" Etudes Et Résultats (Drees) (866)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er866.pdf

[BDSP. Notice produite par MIN-SANTE 7R0xJ98G. Diffusion soumise à autorisation]. Selon le baromètre d'opinion de la DREES, les Français sont plutôt satisfaits de la qualité générale des soins de santé. Avis contrasté cependant selon les types de soins : en 2013, environ 80 % d'entre eux ont une bonne opinion de la qualité des soins chez les dentistes et les médecins, ce taux est de 65 % à l'hôpital public (hors urgence), 60 % en clinique privée et 55 % pour les urgences hospitalières. Ces résultats dépendent aussi de la région d'habitation, les habitants du Bassin parisien et de l'Est de la France étant plus critiques. Pour la première fois en 2012 et 2013, les Français considèrent les inégalités d'accès aux soins comme les moins acceptables.

Cour des Comptes (2014). Les urgences hospitalières : une fréquentation croissante, une articulation avec la médecine de ville à repenser. Rapport sur l'application des lois de financement de la sécurité sociale., Paris : Cour des Comptes : 359-387
https://www.ccomptes.fr/fr/publications/securite-sociale-2014

En 2012, pas moins de 10,6 millions de personnes, près d'un sixième de la population française, sont venues se faire soigner, parfois à plusieurs reprises dans l'année, dans les services d'urgence hospitaliers. Ceux-ci ont enregistré ainsi plus de 18 millions de passages, soit 30 % de plus en dix ans. Pour les seules « structures des urgences », selon leur dénomination règlementaire, situées dans des établissements de santé publics et privés à but non lucratif, qui représentent 81 % du dispositif d'accueil, la charge supportée à ce titre par l'assurance maladie est de près de 2,5 Md€. Cette fréquentation en progression continue met sous tensions persistantes les organisations et les équipes hospitalières en dépit des mesures de renforcement et de soutien successivement décidées par les pouvoirs publics, en particulier dans le cadre du plan urgences 2004-2008 adopté à la suite de la canicule de l'été 2003. Au-delà des situations où le pronostic vital est engagé ou qui nécessitent une intervention rapide compte tenu de leur gravité, les urgences hospitalières jouent de fait un rôle essentiel dans la prise en charge de soins non programmés, à laquelle la médecine de ville n'apporte pas de réponse suffisante. Dans le prolongement de l'enquête qu'elle a précédemment consacrée à la permanence des soins ambulatoires, assurée par les médecins libéraux, où elle avait en particulier souligné le manque d'efficience des dispositifs de régulation et d'orientation mis en place à compter de 2002418, la Cour a cherché à analyser l'évolution de l'activité des services d'urgence et de leur fonctionnement, qu'elle avait déjà

examinés en 2007. Elle a observé que la progression forte de la fréquentation des urgences n'avait fait l'objet jusqu'à tout récemment que de peu d'analyses de ses déterminants. Les services d'urgences ont cherché à faire évoluer leurs organisations pour mieux y répondre, dans un cadre financier inchangé qui contrarie toujours la recherche d'une plus grande efficience. L'amélioration de l'efficacité du dispositif passe cependant avant tout par une articulation plus étroite entre médecine de ville et hôpital.

Cour des Comptes (2019). Les urgences hospitalières : des services toujours trop sollicités. Le rapport public annuel 2019 de la Cour des Comptes. Tome 2., Paris : Cour des comptes **:** 211-239.
https://www.ccomptes.fr/fr/publications/le-rapport-public-annuel-2019

À la suite d'une nouvelle enquête sur les urgences hospitalières, la Cour constate que les améliorations organisationnelles mises en œuvre depuis 2014 à l'hôpital n'ont pas porté tous leurs effets, faute d'un partage des tâches avec la ville permettant de réaliser un véritable virage ambulatoire. Malgré des avancées en termes de recueil des données et d'organisation des services, les urgences demeurent trop sollicitées, entraînant de fréquentes situations de tension dans les établissements (I). La tarification est demeurée complexe et peu propice à un report des prises en charge hospitalières vers une médecine de ville insuffisamment outillée pour les accueillir (II). Désengorger les urgences nécessite de développer les alternatives aux urgences hospitalières en ville, de réorganiser les services d'urgence à l'hôpital et de réformer leurs modalités de financement (III).

Drees (2015). "Résultats de l'enquête nationale auprès des structures des urgences hospitalières." Dossiers Solidarité Et Santé (Drees) (63)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/dss63.pdf

[BDSP. Notice produite par MIN-SANTE Dp79R0xs. Diffusion soumise à autorisation]. Alors qu'on observe une hausse continue de la fréquentation des services d'urgence dans les établissements de santé, les informations disponibles en routine fournissent peu d'éléments sur les motifs de recours, les modalités de prises en charge selon les pathologies, les difficultés rencontrées ou encore la diversité des organisations et de fonctionnement des structures. La Direction de la recherche, des études, de l'évaluation et des statistiques (Drees) a réalisé une enquête un jour donné (le 11/06/2013) auprès des 736 points d'accueil d'urgences présents sur le territoire français. Le colloque de novembre 2014 a permis de présenter les premiers résultats issus de l'exploitation de cette enquête autour de quatre sessions thématiques sur la méthodologie de l'enquête, l'organisation puis la patientèle des services d'urgences et enfin la place des urgences dans l'offre de soins de premier recours.

El Qualidi, M. A. et Saadi, J. (2013). "Améliorer la prise en charge des urgences : apport de la modélisation et de la simulation de flux." Santé Publique 25(4) : 433-439.

[BDSP. Notice produite par EHESP t8s8GR0x. Diffusion soumise à autorisation]. La croissance exponentielle des activités des services des urgences des hôpitaux allonge le temps d'attente des patients et impacte l'usage optimal des ressources destinées au traitement des urgences vitales. La présente étude avait pour objectif de tester et valider différentes stratégies de pilotage, pour minimiser le délai moyen de séjour au service d'accueil des urgences du Centre hospitalier universitaire Ibn Rochd de Casablanca. Nous nous sommes intéressés, dans cette étude, à la modélisation et à la simulation pour décrire le flux de patients au service en question. En termes d'analyse de l'existant, nous avons identifié des goulots d'étranglements au niveau de la consultation de médecine et de la radiologie. Ceux-ci ont

engendré un délai moyen de séjour de six heures. Face à cette situation, une réorganisation de ce service a été proposée et expérimentée par simulation. Les résultats ainsi obtenus ont révélés une réduction de 30% de ce délai. L'étude a montré que le mode organisationnel de travail au service des urgences a un impact significatif sur le délai moyen de séjour.

FHF (2015). Activité des services d'urgence île de France. Année 2014. Paris Fédération Hospitalière de France
https://www.iledefrance.ars.sante.fr/system/files/2017-12/Urgence-rapport-ID-2016_0.pdf

Dans l'objectif de disposer d'une information plus fine sur l'activité des SU de la région, l'Agence a confié la réalisation de ce premier rapport à la Commission Régionale d'Experts Urgences Île-de-France. Ce document est basé sur la remontée, via le système d'information CERVEAU, des données des résumés de passage aux urgences (RPU) de plus de 70% des SU de la région pour l'année 2014. Âge des patients, taux d'hospitalisation, pathologies, sex ratio, gravité, modalités de venues aux urgences, durées des passages, répartition horaire, tous ces indicateurs permettent de construire une représentation objective de l'activité quotidienne des services d'urgence et sont aujourd'hui mis à disposition des professionnels.

Gentile, S., Bongiovanni, I., Delaroziere, J. C., et al. (2001). "L'organisation de la prise en charge des urgences : vers la mise en œuvre d'un réseau." Journal D'économie Médicale 19(5-6) : 371-380

[BDSP. Notice produite par ORSRA R0x5bz4e. Diffusion soumise à autorisation]. La mise en œuvre de réseaux d'urgences devrait se structurer sur la base des réseaux inter-établissements en cours de constitution et s'articuler avec un réseau ville-hôpital, afin de pallier le déficit de coordination actuel entre la médecine de ville et les autres acteurs. Le développement de tels réseaux d'urgences permettrait d'assurer une meilleure cohérence entre les secteurs hospitaliers publics et privés, et la mise en place de liaisons coordonnées entre les secours et les soins, afin de garantir une orientation rapide et adaptée du patient. La mise en place de ces réseaux devra s'accompagner d'une réflexion sur les modes de coordination et les outils d'interfaces nécessaires. (Résumé d'auteur).

Georges-Tarragano, C., Pierru, F., Tapie Delceran, F., et al. (2013). "Surcharge et engorgement des urgences : la réponse durable du modèle des PASS." Sève : Les Tribunes De La Sante (39) : 87-94.

Malgré l'affectation de moyens supplémentaires après chaque séquence de mobilisation de personnels ou de crise de santé publique comme la canicule de 2003, les services d'urgences semblent enlisés dans une crise durable. Une des solutions à cette crise résiderait dans une organisation plus industrielle et productiviste, par le biais notamment de la mise en place d'indicateurs du type "temps d'attente". Pourtant, ce type de réponse accentuerait plutôt les difficultés en incitant les personnels soignant à ignorer les intrications des problématiques médicales, sociales et psychologiques de la plupart des usagers des services d'urgence. Or, il existe un modèle d'organisation qui relève le défi de la prise en compte dans la durée, de la globalité et de la complexité des cas, et qui mériterait d'être soutenu et étendu : les permanences d'accès aux soins de santé (résumé de l'éditeur).

Gouyon, M. (2006). "Les recours aux médecins urgentistes de ville." Etudes Et Résultats (480)

[BDSP. Notice produite par ENSP A56R0xO9. Diffusion soumise à autorisation]. Selon l'enquête menée par la Drees au cours du mois d'octobre 2004, les visites des médecins exerçant au sein d'une association d'urgentistes de ville, telle que SOS Médecins ou Urgences

Médicales de Paris, représentent 5 % des recours urgents ou non programmés à la médecine générale. Les associations d'urgentistes sont dans un tiers des cas sollicitées pour des enfants de moins de 13 ans, souffrant généralement de troubles somatiques. 92 % des déplacements d'urgentistes sont motivés par des affections aiguës, l'état clinique du patient étant d'autant plus critique que celui-ci est âgé. Si la durée moyenne d'une visite est de 17 minutes pour un patient de 13 ans, elle atteint 24 minutes pour une personne de 70 ans, et 40 minutes lorsque le pronostic vital est engagé. Lors d'un recours urgent, les urgentistes de ville dispensent moins de médicaments que leurs confrères généralistes exerçant en cabinet. En revanche, ils prodiguent plus de conseils de prévention et d'hygiène de vie et pratiquent davantage de gestes thérapeutiques. Trois recours sur cinq auprès d'un urgentiste de ville se concluent par une orientation du patient vers un médecin généraliste ou spécialiste, et près d'un sur dix par une hospitalisation.

Gouyon, M. (2009). "Consulter un spécialiste libéral à son cabinet : premiers résultats d'une enquête nationale." Etudes Et Résultats (Drees) (704)
http://www.drees.sante.gouv.fr/IMG/pdf/er704.pdf

[BDSP. Notice produite par MIN-SANTE R0xkr97p. Diffusion soumise à autorisation]. La présente étude dresse un tableau des consultations en cabinet auprès de neuf spécialités, en examinant tant la nature et le caractère urgent ou non du recours que son contenu, les prescriptions qui en découlent et sa durée. Les consultations durent en moyenne 16 minutes chez un ophtalmologiste (comme chez un médecin généraliste), 29 minutes chez un cardiologue et 32 minutes chez un psychiatre. Enfin, à l'exception des pédiatres (34 %) et des ORL (15 %), moins de 10 % des consultations auprès des spécialistes libéraux étudiés relèvent d'une urgence.

Gouyon, M. et Labarthe, G. (2006). "Les recours urgents ou non programmés en médecine générale. Premiers résultats." Etudes Et Résultats (471)

[BDSP. Notice produite par ENSP sMR0xEXy. Diffusion soumise à autorisation]. Selon l'enquête menée par la Drees en octobre 2004 auprès de 1 400 médecins de ville, les recours urgents ou non programmés constituent 12 % de l'activité totale des médecins libéraux. Ils concernent particulièrement des enfants de moins de 13 ans (22 % des patients reçus dans ce cadre) et des adultes de 25 à 45 ans (26 %).

Grall, J. Y. (2006). Les maisons médicales de garde. Paris Ministère chargé de la Santé
https://www.vie-publique.fr/sites/default/files/rapport/pdf/064000564.pdf

Ce rapport, remis à Monsieur Xavier Bertrand, Ministre de la Santé et des Solidarités, établit pour la première fois un état des lieux complet des quelque 200 maisons médicales de garde implantées sur le territoire. Il confirme la pertinence de cette forme d'organisation lorsqu'elle répond à certains critères d'implantation, d'effectifs, de période d'ouverture et de relations avec les structures hospitalières existantes.

Grall, J. Y. (2015). Rapport sur la territorialisation des activités d'urgences. Paris Ministère chargé de la Santé
http://social-sante.gouv.fr/IMG/pdf/2015-07-06_Rapport-Territorialisation_des_Urgences.pdf

Après un bilan de la médicalisation des urgences initiée suite au rapport Steg il y a 20 ans et un état des lieux de l'organisation actuelle des urgences en France, trois grandes

propositions sont avancées : conforter et garantir un accès en moins de trente minutes à la prise en charge de l'urgence ; optimiser la prise en charge de la demande de soins non programmés au sein d'un réseau territorial comprenant l'ensemble des professionnels ou structures concernées, en soulignant dans ce cadre le rôle pivot fondamental de la régulation médicale ; réunir les médecins urgentistes au sein d'équipes territoriales uniques dans le cadre des futurs Groupements Hospitaliers de Territoire (GHT). Un groupe de travail sera mis en place afin de préciser les modalités de mise en œuvre des recommandations retenues en cohérence avec les évolutions de l'organisation territoriale portées par le projet de loi de modernisation de notre système de santé.

Hastings, S. N. (2011). Modalités de prise en charge d'un appel de demande de soins non programmés dans le cadre de la régulation médicale. Recommandations professionnelles. Paris HAS https://www.has-sante.fr/upload/docs/application/pdf/2011-10/reco2clics_regulation_medicale.pdf

[BDSP. Notice produite par HAS lR0xnpoF. Diffusion soumise à autorisation]. L'objectif de ces recommandations est d'améliorer la qualité et la sécurité de la réponse apportée aux patients ; constituer un support pour la formation continue des professionnels et l'évaluation de leurs pratiques et favoriser l'harmonisation des pratiques entre professionnels et sur l'ensemble du territoire.

Houssain, D. (2007). "Le temps de la santé : l'urgence." Sève : Les Tribunes De La Sante (13) : 33-38.

L'urgence occupe une place considérable et croissante dans le champ de la santé. Autour de la notion de durée limite propre à certains mécanismes physiologiques indispensables à la poursuite de la vie, c'est peu à peu structurée une organisation des soins apte à répondre dans le temps aux exigences posées dans le domaine de la médecine. Il en a résulté un effort important d'adaptation dans le champ de ma médecine libérale comme dans celui des établissements de santé. Sans être une médecine d'exception, la médecine d'urgence est toutefois particulière, en raison des contraintes qui pèsent sur certains aspects fondamentaux de sa pratique. Le domaine de la santé publique n'échappe pas au phénomène de l'urgence. Tel est le sujet de cet article.

Institut Montaigne (2013). Accès aux soins : en finir avec la fracture territoriale. Paris Institut Montaigne
http://www.institutmontaigne.org/fr/publications/acces-aux-soins-en-finir-avec-la-fracture-territoriale

Très onéreux, d'une grande complexité institutionnelle et administrative, le système de soins français pèche également par l'archaïsme de son organisation, caractérisé par de forts cloisonnements entre ville et hôpital comme entre professionnels de santé. Au-delà des problèmes évidents de répartition sur le territoire des professionnels de santé, la question est sans doute plutôt celle du modèle d'organisation des soins en France, qui ne correspond plus aux exigences sociales, démographiques et technologiques de notre pays. Face à ces défis et dans un contexte de finances publiques contraint, comment adapter notre système de santé ? C'est vers une organisation décloisonnée, régionalisée, construite autour des besoins des patients qu'il faut s'orienter. Le système de santé doit également s'adapter aux exigences des nouvelles générations de professionnels de santé et leur offrir les moyens d'exercer leur métier de façon regroupée, en bénéficiant de l'apport des nouvelles technologies.

Jourdain Menninger, D. et Aballea, P. (2004). Rapport d'évaluation de la consultation pédiatrique sans rendez-vous de l'hôpital Robert Debré de l'Assistance publique-Hôpitaux de Paris, et recommandations pour les réseaux d'urgence ville hôpital à Paris et en Seine-Saint-Denis. Paris IGAS
https://www.vie-publique.fr/sites/default/files/rapport/pdf/044000462.pdf

Une expérimentation de consultation sans rendez-vous a été installée en décembre 2003 au sein de l'hôpital de l'hôpital Robert Debré, auprès du service d'urgence pédiatrique. Destinée à alléger les délais d'attente et à améliorer les conditions d'accueil des usagers et les conditions de travail du personnel, cette consultation a été confiée à un Centre de santé parisien, le centre médical Europe. Il a donc été demandé à l'IGAS de procéder à l'évaluation de la consultation sans rendez-vous de l'hôpital Robert Debré, et de faire des recommandations concernant les dispositifs susceptibles d'alléger la charge des services des urgences lorsque le recours à ces services ne se justifie pas. La mission a placé l'ensemble de ses investigations dans le cadre de la permanence des soins, à Paris et en Seine-Saint-Denis. Compte tenu de son objet, la mission a élargi son analyse aux dispositifs apportant des réponses aux patients ayant une demande de soins non programmés par les hôpitaux, aux dispositifs de soins de ville et à leur régulation (résumé d'auteur).

Kuhn-Lafont, A. et Broussy, L. (2019). Objectif grand âge : Eviter l'hôpital. Paris Matières grises
https://www.silvereco.fr/wp-content/uploads/2019/07/Rapport-Think-Tank-mati%C3%A8res-grises.pdf

Ce rapport est une synthèse des causes et des effets des hospitalisations des personnes âgées mais surtout qui rappelle les différents leviers pour les éviter : développement du tarif global et des pharmacies à usage intérieur, déploiement de l'HAD, continuité des soins la nuit en EHPAD, télémédecine, formation des équipes soignantes aux situations d'urgence, développement de l'hébergement temporaire en sortie d'hôpital… Ce document dresse un panorama des dispositifs identifiés et déjà connus pour lutter efficacement contre les hospitalisations évitables des personnes âgées et rappelle le rôle déterminant des EHPAD pour la mobilisation de ces leviers.

Le Spegagne, D. et Cauterman, M. (2005). Rapport de fin de mission "Temps d'attente et de passage aux urgences" juillet 2003- mars 2005. Paris Ministère chargé de la santé
http://urgentologue.free.fr/dmdocuments/organisation/sau/MeaH/2005-06%20-%20temps%20d'attente%20aux%20Urgences%20-%20fin%20mission.pdf

De juillet 2003 à avril 2005, la MeaH a accompagné 8 services d'Urgences volontaires pour s'engager dans une démarche de réduction des temps de prise en charge des patients. Le diagnostic organisationnel a mis en évidence des performances (en terme de temps de passage des patients) variables d'un site à l'autre et selon les profils de patients. Si le niveau de ressources n'est pas un déterminant du niveau de performance, l'analyse qualitative des organisations a permis en revanche d'expliquer des temps de prise en charge plus ou moins longs. L'analyse approfondie de l'organisation de chaque service et la comparaison entre les sites ont permis aux professionnels d'élaborer des plans d'actions dans l'objectif de diminuer les temps de passage des patients. Ces plans d'actions, plus ou moins en adéquation avec le diagnostic et mis en œuvre à des degrés divers, ont donné des résultats variables selon les sites : si la majorité des services a réussi à diminuer le nombre de patients pris en charge dans un délai jugé excessif

Le Douarin, M. et Chicoye, A. (2014). "Efficience économique des maisons médicales de garde : l'exemple du Val-de-Marne." Médecine : Revue De L'unaformec 10(3) : 134-139.

> Management of unscheduled and out-of-hours services is a topical issue in France and throughout Europe. This study provides an assessment of costs and efficiency of Medical Care Centres in the department of Val-de-Marne. Method. We estimated the average cost of care per patient in the Medical Care Centres and Hospital Emergency Services in the department of Val-de-Marne (key consideration) and the impact of the creation of the Association of Medical Care Centres on the activity of various structures over the period of observation (secondary consideration). In 2011, 36,473 patients were supported for a total of e 3,359,915 or e 92.10 per passage (average cost for 14 Hospital Emergency Services of the Val-de-Marne : e 144.90). The threshold efficiency calculated for Medical Care Centres is 3 passes for work on duty from 8pm to midnight and 2 for those weekends and holidays. Over the 2008-2011 period, The Ile-de-France region experienced an increase of 10.4% in attendance Hospital Emergency Services, in Val-de-Marne it was significantly less (6.4%). Conclusion. This study shows the economic efficiency of the medical facility. A more detailed analysis could not be carried out due to insufficient data.

Levasseur, G., Bataillon, R. et Samzun, J. L. (2004). Baromètre des pratiques en médecine libérale : Synthèse des résultats "emploi du temps : une semaine en hiver en médecine générale". Rennes URMLB

> En octobre 2003, les résultats de l'enquête " conditions de travail " du Baromètre des pratiques mettaient en évidence certains faits concernant le travail des médecins généralistes. Ces résultats détaillaient à la fois des aspects connus de la pratique (longue durée du temps de travail hebdomadaire) et certains aspects moins connus tels la place des consultations non programmées ou celle des conseils téléphoniques. Pour donner une vision aussi complète que possible de l'activité du médecin généraliste, les membres du comité de pilotage du " Baromètre " ont souhaité répéter la même enquête en période hivernale. C'est l'objet de ce rapport réalisé à partir d'une enquête par questionnaire auprès d'un panel de 120 généralistes représentatifs des généralistes bretons, une semaine en hiver. On obtient des précisions sur l'activité hebdomadaire et ses variations dans la semaine des médecins généralistes : nombre de jours de travaillés par semaine, jours de non activité préférentiels, nombre d'heures de travail hebdomadaire et quotidien, amplitude horaire d'ouverture du cabinet médical, horaires de fin de travail et travail après 20 heures, nombre d'actes, consultations programmées et non programmées au cours de la semaine, visites, actes d'urgences, conseils prodigués par téléphone, gardes.

Malone, A. (2017). "Améliorer le fonctionnement des urgences : Le rôle crucial des caractéristiques organisationnelles." Revue Hospitalière De France (578) : 12-14.

> [BDSP. Notice produite par EHESP 9GE8R0xt. Diffusion soumise à autorisation]. Améliorer l'efficacité des services d'urgence est une préoccupation partagée dans l'ensemble des systèmes de santé avancés. Pour autant, la connaissance du type de stratégie opérante demeure lacunaire et insuffisamment documentée, malgré un très grand nombre d'initiatives. Pourquoi certains hôpitaux réussissent-ils mieux que d'autres ? Une recherche originale mêlant données quantitatives et approches qualitative, conduite sur des hôpitaux américains, apporte des éléments de réponse. Sa principale conclusion est que le succès ou l'échec, en la matière, repose sur la présence ou l'absence de caractéristiques organisationnelles, bien plus que dans l'adoption de tel outil ou pratique. Incidemment, cet

article illustre une méthode fréquente en recherche qualitative : la théorie ancrée (grounded theory). (R.A.).

Malone, A. (2017). "Un nouveau modèle pour les urgences rurales : Associer urgences et soins primaires." Revue Hospitalière De France (579) : 6-7

[BDSP. Notice produite par EHESP HR0xGpsk. Diffusion soumise à autorisation]. La question des services d'urgence en milieu rural revient régulièrement sur le devant de la scène et leur survie est parfois remise en question. Pour autant, les populations de milieu rural font face à de graves enjeux de santé publique, qui se couplent à des interrogations persistantes sur l'accès aux services dans ces zones souvent associées aux "déserts médicaux". Ces enjeux concernent tous les pays développés. L'article présenté ici propose un nouveau modèle susceptible d'assurer l'avenir de ces structures, et surtout de mieux répondre aux besoins des populations. En s'appuyant sur une expérience pilote menée en Caroline du Nord (USA), les auteurs tracent les contours de services d'urgence répondant au triple objectif d'un meilleur soin pour le patient, d'une meilleure santé pour la population, au meilleur coût pour la société. (R.A.).

Mesnier, T. (2018). Assurer le premier accès aux soins : organiser les soins non programmés dans les territoires. Paris Ministère chargé de la santé
https://solidarites-sante.gouv.fr/IMG/pdf/rapport_snp_vf.pdf

A la demande du ministre des solidarités et de la santé, la mission avait pour but de dresser un diagnostic des organisations de prise en charge des soins non programmés – définis comme exprimant une demande de réponse en 24 heures à une urgence ressentie relevant prioritairement de la médecine de ville, de recueillir les attentes des usagers et des professionnels de santé, de recenser les expériences et stratégies des ARS, d'identifier les freins à l'accueil de cette demande, et de proposer les éléments que pourrait intégrer un cahier des charges national afin de définir les modalités minimales de fonctionnement et de portages de structures d'accueil des soins non programmés. Il fait le constat unanimement partagé du besoin pressant de structuration de la réponse à la demande de soins non programmés par les acteurs de médecine ambulatoire, pour éviter que celle-ci ne se déporte par défaut sur les urgences hospitalières et n'en altère le bon fonctionnement.

Mesnier, T. et Carli, P. (2019). Rapport pour un pacte de refondation des urgences. Paris Ministère chargé de la santé
https://solidarites-sante.gouv.fr/actualites/presse/article/pacte-de-refondation-des-urgences-20-decembre-2019

Le rapport complet « Pour un pacte de refondation des urgences » a été remis par le député Thomas MESNIER et le professeur Pierre CARLI, le 20 décembre 2019. Il intègre les travaux de l'équipe projet associant le Dr. Laurent Brechat (médecin libéral à la maison de santé pluridisciplinaire d'Avoine en Indre-et-Loire), le Dr. Patrick Goldstein (médecin chef du SAMU 59), le Dr. Alain Prochasson (médecin libéral à Metz et président de l'Association départementale de permanence des soins de Moselle) et Vanessa Solviche (cadre de santé du SAMU 57). Cette étude rassemble plusieurs préconisations. Le tome 1 aborde l'ensemble des pistes de réflexions pour participer à la refondation des urgences, dans la continuité de la stratégie « Ma Santé 2022 » avec une approche globale des parcours de soins urgents (amont, urgences en elles-mêmes et aval) ; le tome 2 analyse de manière plus approfondie et technique cinq mesures spécifiques : l'organisation du service d'accès aux soins, la gradation

des services d'urgence, la réforme des transports médicalisés, la formation des médecins et les permanences d'accès aux soins de santé (PASS).

Michel, P. (2003). Les urgences de nuit d'un généraliste
https://bdsp-ehesp.inist.fr/vibad/index.php?action=getRecordDetail&idt=339082

Ce travail a pour but d'analyser l'activité d'un médecin généraliste en garde de nuit, de décrire les patients et les pathologies rencontrées selon différentes classifications.

Ministère chargé de la Santé (2003). Le temps d'attente aux urgences : rapport d'étape. Paris Ministère chargé de la santé
https://bdsp-ehesp.inist.fr/vibad/index.php?action=getRecordDetail&idt=299398

La Mission nationale d'expertise et d'audit hospitaliers (MeaH) a été créée par la LFSS pour 2003. Avec la Mission " Tarification à l'activité " et la Mission " Aide à l'investissement ", elle fait partie des trois missions opérationnelles installées par le ministre de la Santé pour mettre en œuvre le Plan Hôpital 2007. L'ensemble des missions conduites par la Meah vise à faire émerger "une meilleure organisation des activités hospitalières qui combine qualité du service rendu au patient, efficience économique et conditions de travail satisfaisantes pour le personnel". 6 thèmes figuraient au programme de travail 2003 : le temps d'attente aux urgences, le temps de travail des médecins, l'organisation des services de radiothérapie, les achats dans les hôpitaux et cliniques, l'organisation des services d'imagerie, la mise en œuvre de la comptabilité analytique. Les quatre premiers ont été lancés en juillet 2003 et ont fait l'objet de rapports d'étape accessibles sur le site Internet de la mission. Les premiers constats dégagés jettent une lumière crue sur les pratiques de l'hôpital. Ce document concerne les temps d'attente aux urgences, et démontre qu'ils peuvent varier du simple au double d'un site à l'autre. Quel que soit le thème abordé par la mission, la conclusion est la même : il y a des services bien gérés, d'autres moins, des organisations efficaces et d'autres qui ne permettent pas d'assurer une bonne prise en charge des malades. Le site de la mission : http://www.meah.sante.gouv.fr. La plaquette de présentation du programme de travail 2004 comportant une synthèse des chantiers ouverts en 2003 disponible au format Pdf.

Ministère chargé de la Santé (2008). Organisation du secours à la personne et de l'aide médicale urgente. Paris Ministère chargé de la santé
https://www.interieur.gouv.fr/Le-ministere/Securite-civile/Documentation-technique/Les-sapeurs-pompiers/Les-services-departementaux-d-incendie-et-de-secours/Organisation-du-secours-a-personne-et-de-l-aide-medicale-urgente

Ce rapport présente le référentiel commun qui permettra de mieux organiser la prise en charge des appels arrivant au 15 et/ou au 18. Ce référentiel a été élaboré dans le cadre d'un groupe de travail quadripartite associant les représentants des structures de médecine d'urgence, des services d'incendie et de secours et des services des ministères concernés.

Morel, S. (2019). "Inequality and discrimination in access to urgent care in France Ethnographies of three healthcare structures and their audiences." Soc Sci Med 232 : 25-32.

In the social imagination, there is no wait for a so-called "medical emergency," because it seems obvious to everyone that "saving lives" is not up for discussion. In the context of such social consensus, it is unthinkable to question access to emergency healthcare through the

prism of discrimination and social inequality. Yet these social representations of emergency do not withstand ethnographic inquiry. Several years spent behind the scenes in this world revealed that there do in fact exist social selection practices in the realm of emergency care in France. More specifically, this study shows that medical interests and the interests of both public and private institutions have led to the production of socially differentiated pathways of access to emergency care. The first pathway is through private, for-profit clinics, the second is through public hospitals, a third occurs by "bypassing" the emergency department, and a final one groups the non-governmental social and health assistance structures. In this article, we discuss the specific mechanisms they have for selecting patients, and show how the organization of emergency care in France contributes to reproducing or even aggravating inequalities in health and access to healthcare.

Or, Z. et Penneau, A. (2017). Analyse des déterminants territoriaux du recours aux urgences non suivi d'une hospitalisation. Document de travail Irdes ; 72. Paris Irdes
http://www.irdes.fr/recherche/documents-de-travail/072-analyse-des-determinants-territoriaux-du-recours-aux-urgences-non-suivi-d-une-hospitalisation.pdf

Les services d'urgence sont essentiels au système de santé afin de traiter rapidement les situations d'urgences médicales. Ils sont cependant souvent utilisés pour des prises en charge non urgentes pouvant être réalisées dans le secteur ambulatoire. La rapide augmentation du volume de passages aux urgences, particulièrement chez les sujets âgés, est une source de pression pour les hôpitaux et le système de soins. Cette étude a pour objectif d'identifier les déterminants territoriaux du recours aux urgences non suivi d'hospitalisation des personnes âgées de 65 ans et plus.

Praznoczy-Pepin, C. (2007). Les recours urgents ou non programmés en médecine générale en Ile-de-France. Urgences en médecine générale. Paris ORSIF
https://www.ors-idf.org/fileadmin/DataStorageKit/ORS/Etudes/2007/Etude2007_7/2007_recoursSoins_urgences_1_.pdf

Basée sur une enquête réalisée par la Direction de la recherche ? Des études et de l'évaluation et des statistiques (Drees) dans toutes les régions de France métropolitaine, en octobre 2004, cette étude analyse les recours urgents ou non programmés en médecine générale en Ile-de-France. Les médecins concernés sont les libéraux exerçant ou non au sein d'une association d'urgentistes. L'analyse porte sur les caractéristiques socio-démographiques des patients, les motifs de recours, la durée des séances, les prescriptions d'actes et les orientations à la suite des visites et consultations.

Ricroch, L. (2015). "Urgences hospitalières en 2013 : des organisations différentes selon le niveau d'activité." Etudes Et Résultats (Drees) (906)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er906.pdf

[BDSP. Notice produite par MIN-SANTE GI8DkR0x. Diffusion soumise à autorisation]. Les points d'accueil des urgences, répartis sur tout le territoire, sont majoritairement situés dans des établissements de santé publics. Leur organisation et leurs ressources sont variables : tous n'ont pas de poste d'accueil et d'orientation, d'assistance sociale, de psychiatre ou d'accès prioritaire à une imagerie par résonance magnétique (IRM). Cette organisation dépend du volume de passages, du statut de l'établissement et de sa spécialisation ou non en pédiatrie. Les points d'accueil dont les ressources en matériel ou en personnel sont les plus importantes reçoivent le plus de patients. Le personnel des urgences dans les

établissements publics est plus nombreux que dans les établissements privés. A contrario, ces derniers disposent d'équipements plus nombreux ou de plus de personnels, en dehors du service des urgences, dédiés à l'affectation des patients, à l'obtention des lits et à la tenue d'un tableau de bord.

Ricroch, L. et Vuagnat, A. (2015). "Urgences : sept patients sur dix attendent moins d'une heure avant le début des soins." Etudes Et Résultats (Drees) (929)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er929.pdf

[BDSP. Notice produite par MIN-SANTE 8qkR0xpJ. Diffusion soumise à autorisation]. Neuf patients sur dix sont accueillis et orientés dans la demi-heure qui suit l'arrivée aux urgences ; le début des soins est effectué dans l'heure pour sept patients sur dix. Cette prise en charge médicale est d'autant plus rapide que l'état de la personne est jugé grave : patient amené par le service mobile d'urgence, accueil en salle des urgences vitales, détresse respiratoire ou douleur thoracique. L'étendue des actes et des soins réalisés aux urgences, avec éventuellement un recours au plateau technique, détermine la durée de passage : ainsi, un parcours aux urgences sans actes ni soins dure moins de 76 minutes pour la moitié des patients, contre 106 minutes pour un parcours avec une radiographie. La disponibilité de lits influe sur la durée de passage aux urgences. La recherche d'une place d'hospitalisation prend plus de 50 minutes dans la moitié des cas dès que plusieurs appels sont nécessaires pour l'obtenir.

Ricroch, L. et Vuagnat, A. (2017). "Les hospitalisations après passage aux urgences moins nombreuses dans le secteur privé." Etudes Et Résultats (Drees) (997)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er997.pdf

[BDSP. Notice produite par MIN-SANTE F9R0xnDA. Diffusion soumise à autorisation]. Mardi 11 juin 2013, un quart des passages aux urgences de patients âgés de 15 ans et plus se poursuivent par une hospitalisation dans un autre service. La décision d'hospitalisation se fonde principalement sur l'état de santé des patients : le motif de recours aux urgences, la gravité associée au diagnostic, la présence de pathologies au long cours, l'avancée en âge. D'autres facteurs, comme l'éloignement important des urgences, sont associés à une fréquence plus élevée de décision d'hospitalisation : un tiers des patients pris en charge à plus de 20 km de leur domicile sont hospitalisés. Le taux d'hospitalisation depuis les urgences apparaît moins élevé dans les établissements de santé privés à but lucratif (15 %) que dans les établissements de santé publics (26 %).

Roberge, D., Larouche, D., Pineault, R., et al. (2002). "Les unités d'urgence hospitalières dans un réseau en transformation : l'expérience montréalaise." Gestions Hospitalières (420) : 706-711.

[BDSP. Notice produite par APHPDOC bOXR0x0q. Diffusion soumise à autorisation]. Dans les grandes régions urbaines du Québec, des problèmes chroniques d'engorgement dans les unités d'urgence (UU) se sont manifestés. Ils ont motivé l'élaboration d'un projet reposant sur une étude de cas multiples qui montre les efforts déployés par les hôpitaux pour mettre en place le virage ambulatoire (diminution des séjours hospitaliers et augmentation des soins d'un jour), et la hausse de productivité qui en découle. Malgré cela, on assiste à une détérioration des situations dans les UU ces toutes dernières années. (D'après R.A.).

Samu Urgences France (2015). Livre blanc : organisation de la médecine d'urgence en France : un défi pour l'avenir. Paris Samu Urgences France

Réalisé par Samu Urgences France, ce rapport dresse tout d'abord un bilan de l'organisation de la médecine d'urgence en France : Samu, Smur, permanence de soins, SOS médecins, etc. Il souligne l'inadéquation actuelle de l'offre à la demande, qui a beaucoup évolué ces dernières années avec le développement des maladies chroniques et du vieillissement de la population. Afin de répondre à la demande future, il propose enfin 20 propositions.

Staeger, P., Amstutz, V., Perdrix, J., et al. (2012). "Urgences et médecins de premier recours : quelles perspectives ? Quelle formation ?" Revue Medicale Suisse 8(364) : 2266-2271. https://www.revmed.ch/RMS/2012/RMS-364/Urgences-et-medecins-de-premier-recours-quelles-perspectives-Quelle-formation

La professionnalisation de la médecine d'urgence et le triage en amont de la plupart des consultations d'urgence ont abouti à une diminution importante de l'exposition des médecins de premier recours (MPR) aux urgences vitales, réduisant ainsi leurs aptitudes à gérer ces situations qui, si elles sont devenues plus rares, n'ont pas pour autant complètement disparu de leur pratique. Il reste donc important que les MPR préservent les compétences nécessaires à une prise en charge initiale adéquate de ces urgences. On pensera notamment à la capacité de reconnaître les symptômes et signes d'alarme, d'appliquer les gestes qui sauvent la vie, et de trier correctement les patients. Ces compétences seront d'autant plus importantes dans le futur, où le rôle des MPR pourrait se renforcer en réponse aux exigences d'efficience accrue.

Stagnara, J., Vermont, J., Jacquel, J., et al. (2010). "Réduction des consultations non programmées et non justifiées dans le cadre des urgences pédiatriques grâce à une plateforme téléphonique." Presse Medicale (La) 39(11) : E258-E263.

Les consultations non programmées et non médicalement justifiées dans les services d'urgence augmentent. Il est nécessaire d'agir sur la demande non justifiée de soins. Des plateformes téléphoniques dédiées à la santé des enfants pourraient être un moyen efficace de diffuser de manière standardisée les référentiels factuels pour les cas cliniques jugés urgents par les parents ou accompagnants d'enfants et ne nécessitant pas, dans la majorité des cas, une prise en charge dans les services d'urgences. Nous avons étudié la faisabilité de la mise en place d'une plateforme téléphonique, en dérivation du système en vigueur pour la régularisation des appels d'urgence (Samu, Centre 15) et son effet sur la réduction du nombre de consultations non programmées dans les services d'urgences. Les référentiels développés par l'association Courlygones de Lyon et fondés sur des données factuelles à propos de 5 thèmes (fièvre, diarrhée, pleurs, traumatisme crânien et gêne respiratoire chez le jeune enfant) ont été standardisés et adaptés à la communication téléphonique. Une équipe formée de répondants (infirmières puéricultrices) a été placée en dérivation du système de prise en charge afin de diffuser ces référentiels. Un appel à ces familles 7 jours plus tard a permis de connaître les actions qui ont suivi cet appel et les informations retenues par les appelants. La satisfaction de cette prise en charge a été évaluée.

Steg, A. (1993). Rapport sur la médicalisation des urgences. Paris Ministère chargé de la santé

Résultats de la Commission Nationale de Restructuration des Urgences (CNRU) créée en septembre 1991, dont l'objectif principal était de définir dans les deux ans les voies et les moyens pour "mieux prendre en charge les patients accueillis en urgence" en France. Ce

document n'envisage pas l'ensemble des problèmes posés par l'accueil des urgences mais se veut essentiellement un rapport sur la médicalisation des urgences.

Toulemonde, F. d. et Boisguerin, B. c. (2019). Les établissements de santé : édition 2019, Paris : Drees https://drees.solidarites-sante.gouv.fr/IMG/pdf/es2019.pdf

En 2017, plus de 3 000 établissements de santé assurent le diagnostic, la surveillance et le traitement des malades. Dans un contexte marqué par le vieillissement de la population et l'augmentation des pathologies chroniques, les structures hospitalières, dont le nombre continue de diminuer, s'adaptent et modifient en profondeur leur offre de soins, par le biais notamment du développement de l'hospitalisation à temps partiel ou de l'hospitalisation à domicile. Dans son édition 2019, Les établissements de santé détaille, pour l'année 2017, les capacités d'accueil et l'activité des hôpitaux et cliniques, le parcours des patients par disciplines, les caractéristiques du personnel rémunéré (médical et non médical) ou encore les équipements techniques et leur répartition sur le territoire. Les nouveaux indicateurs mis à disposition par la Haute Autorité de santé (HAS) pour évaluer la qualité des soins et la sécurité des patients sont présentés de façon synthétique. Enfin, des éléments de cadrage permettent d'apprécier l'évolution de la santé économique et financière du secteur, ainsi que de son contexte juridique et réglementaire.

Wartelle, A., Mourad-Chehade, F., Yalaoui, F., et al. (2020). "Impact de nouvelles cliniques sur les fréquentations des urgences : une étude avant après basée sur un « clustering » de flux patients." Revue D'épidémiologie Et De Santé Publique 68
http://www.sciencedirect.com/science/article/pii/S0398762020300183

Introduction En France, le nombre d'admissions aux urgences a doublé entre 1996 et 2016 avec une croissance moyenne de 3,5 % par an. Face aux problèmes de saturation engendrés, la redirection des flux de patients vers de nouvelles structures est l'une des solutions proposées afin de mieux répartir la demande et de rendre l'offre plus efficiente. L'étude de l'évolution des passages aux urgences pourrait permettre d'évaluer l'impact de ces nouvelles structures. L'objectif de cette étude est d'évaluer l'impact de l'ouverture de structures de soins non programmés sur les consommations de soins au service des urgences à partir des variations de profils patients dans le temps. Méthodes Nous avons mené une étude avant–après portant sur l'ensemble de la consommation de soins au sein du département de l'Aube (Grand Est, France) et en particulier celle du service d'urgence du Centre hospitalier de Troyes à partir de sa base de données ResUrgences. Nous avons proposé une méthode de « clustering » hiérarchique pour segmenter la population selon leurs différents diagnostics CIM-10. Cette méthode utilise une nouvelle mesure de distance, entre diagnostics CIM-10, fondée sur un lien statistique de comorbidité et une similarité lexicale. Un modèle multivarié de régression logistique, modélisant la probabilité pour un passage d'appartenir à un des clusters en baisse, a été évalué pour ajuster l'effet de période sur différents facteurs de confusion. Résultats Au total, 126 061 passages aux urgences ont été observés sur une période de 24 mois (2017–2019). Les 20 clusters les plus volumineux, représentant 68,95 % de la population, ont été sélectionnés. L'analyse avant-après montrait une baisse moyenne de 45,9 passages (3,8 % du volume total) par semaine pour ces 20 clusters. La probabilité d'appartenance à ces clusters a diminué après l'ouverture avec un OR de 0,90 (IC95 % [0,84, 0,95]) traduisant l'impact des nouvelles structures de soins non programmés. Discussion/Conclusion Cette méthode pourrait être généralisée pour évaluer la mise en place de structures concurrentielles aux services d'urgences et de soins non programmés.

ÉTUDES INTERNATIONALES

(2015). "Hospital admissions increasingly are originating in urgent care." Healthc Financ Manage 69(9) : 120-121.

(2017). "More people accessing urgent care due to NHS 111." Emerg Nurse 24(10) : 7.

The NHS's 111 non-emergency phone line is sending a rising number of patients for emergency care, new analysis shows.

Adigun, A. C., Maguire, K., Jiang, Y., et al. (2019). "Urgent Care Center and Emergency Department Utilization for Non-Emergent Health Conditions: Analysis of Managed Care Beneficiaries." Popul Health Manag 22(5) : 433-439.

The objective was to identify predictors of utilization for urgent care centers (UCCs), emergency departments (EDs), or for both services for non-emergent health conditions among beneficiaries from a managed care organization (MCO) who resided within a 10-mile radius of UCCs. A cross-sectional design was used to analyze 2016 administrative claims data from an MCO that contracted with a UCC with 12 locations (n = 20,107). Outcome variables were number of visits to UCC, ED, or both. The MCO used the New York University ED algorithm to identify non-emergent health conditions. The Behavioral Model of Health Care Utilization was used as a conceptual framework to identify predictors in the model; age, sex, race/ethnicity, distance to UCC from residence, type of insurance, primary care physician visits, inpatient admissions, chronic conditions, morbid obesity, and smoking behavior. Generalized linear models were used to analyze the association between outcomes and predictors. About 22.7% were UCC users, 66.8% were ED users, and 10.5% used both. African Americans (incident rate ratio [IRR] = 0.95; 95% confidence interval [CI]: 0.91-0.98] were less likely to use UCCs and more likely to use the ED (IRR = 1.10; 95% CI: 1.07-1.13). Beneficiaries with multiple chronic conditions were more likely to use the ED than UCCs. Distance was not a predictor of UCC or ED usage. Utilization of UCC was low for non-emergent health conditions. African Americans and individuals with multiple chronic conditions preferred the ED to UCC for non-emergent health conditions. This study implies that MCO beneficiaries, especially the African American population, need to be informed about UCC locations and services provided.

Albert, D. J. (2015). "Primary care is not urgent care, and we need more urgent care." BMJ 350 : h2218.

Alberti, T. L. et Crawford, S. L. (2019). "Health information-seeking behaviors and adherence to urgent care discharge instructions." Health Expect.

BACKGROUND: Although studies suggest that most patients use healthcare professionals as the main source of health information, the ease of Internet access has resulted in a growing number of people who seek health information from other sources. Health information-seeking skills and patterns may influence follow-through with treatment recommendations. PURPOSE: The purpose of this study was to explore the health information-seeking behaviors (HISBs) of urgent care (UC) patients and the association to adherence to discharge instructions. METHODS: A HISB questionnaire was administered to adults presenting for care at a UC clinic. A repeated measure of HISB and the Medical Outcomes Study General Adherence Scale were administered 10-14 days after UC visit. Descriptive and bivariate

analyses determined HISB and their association with discharge instruction adherence. RESULTS: Two hundred ten patients completed all surveys. Family and friends were the most common health information source used both before and after an UC visit. Seeking health information through family/friends after the visit was negatively associated with adherence (covariate adjusted p value, .0003). IMPLICATIONS FOR PRACTICE: At times of episodic illness, patients tend to seek health information from family and friends with greater frequency than traditional medical, online, or paper sources. Nurse practitioners working in UC or emergent care settings should include family and friends at the time of discharge teaching because patients may use these sources for additional health information, which may affect instruction adherence.

Anderson, T. J. et Althausen, P. L. (2016). "The Role of Dedicated Musculoskeletal Urgent Care Centers in Reducing Cost and Improving Access to Orthopaedic Care." J Orthop Trauma 30 Suppl 5 : S3-s6.

OBJECTIVES: Over the past few years, the United States has seen the rapid growth of dedicated musculoskeletal urgent care centers owned and operated by individual orthopaedic practices. In June of 2014, our practice opened the first dedicated orthopaedic urgent care in the region staffed by physician assistants and supervised by orthopaedic surgeons. Our hypothesis is that such centers can safely improve orthopaedic care for ambulatory orthopaedic injuries, decrease volume for overburdened emergency departments (EDs), reduce wait times and significantly decrease the cost of care while improving access to orthopaedic specialists. DESIGN: Retrospective review. SETTING: Level 2 trauma center and physician-owned orthopaedic urgent care. PATIENTS: Consecutive series of patients seen in the hospital ED (n = 87,629) and orthopaedic urgent care (n = 12,722). INTERVENTION: None. OUTCOMES: ED wait time, total visit time, time until being seen by provider, time until consultation with orthopaedic surgeon, total visit charges, and effect on orthopaedic practice revenue. RESULTS: During the 12 months of study, 12,722 patients were treated in our urgent care. The average urgent care wait time until being seen by a provider was 17 minutes compared with 45 minutes in hospital ED. Total visit time was 43 minutes in the urgent care and 156 minutes in the hospital ED. Time to being seen by an orthopaedic specialist was 1.2 days for urgent care patients compared with 3.4 days for ED patients. The average charge for an urgent care visit was $461 compared with $8150 in hospital ED. During the course of study, urgent care treatment reduced charges to health care system by $97,819,458. Hospital ED orthopaedic volume did decrease as expected but total ED patient volume remained the same. There was no measureable effect on hospital ED wait times. Hospital surgical case volume did not change over the period of study and the orthopaedic census remained stable. Urgent care construction, marketing, administration, imaging, and labor costs totaled $1,664,445. Urgent care revenue from evaluation and management, imaging, durable medical equipment, and casting totaled $2,577,707. Practice revenue from follow-up care of patients who entered practice through the urgent care totaled $7,657,998. CONCLUSION: Dedicated musculoskeletal urgent care clinics operated by orthopaedic surgery practices can be extremely beneficial to patients, physicians, and the health care system. They clearly improve access to care, whereas significantly decreasing overall health care costs for patients with ambulatory orthopaedic conditions and injuries. In addition, they can be financially beneficial to both patients and orthopaedic surgeons alike without cannibalizing local hospital surgical volumes. LEVEL OF EVIDENCE: Therapeutic Level III.

Ashton, L. M. (2017). "Urgent care: A growing healthcare landscape." Nurs Manage 48(9) : 48-54.

Aungst, L. A. (2019). "Can telemedicine improve triage and patient satisfaction in urgent care settings?" J Am Assoc Nurse Pract 31(3) : 162-166.

Urgent care centers (UCCs) frequently experience long wait times, overcrowding, and patient dissatisfaction. According to recent studies in the emergency care setting, utilization of telemedicine during patient triage has demonstrated reduction in patient wait time and improvement in patient satisfaction. Implementation of telemedicine in urgent care settings may make triage faster and more efficient and lead to similar improvements in wait time and patient satisfaction. Finally, there is potential for telemedicine to improve working conditions for providers and staff of UCCs.

Avdic, D. (2014). A matter of life and death? Hospital distance and quality of care: evidence from emergency room closures and myocardial infarctions. HEDG Working Paper 14/18. York HEDG http://www.york.ac.uk/media/economics/documents/hedg/workingpapers/1418.pdf

Recent health care centralization trends raise the important question of the extent to which the quality of emergency medical services may offset effects from decreased access to emergency health care. This article analyzes whether residential proximity from an emergency room affects the probability of surviving an acute myocardial infarction (AMI). The critical time aspect in AMI treatment provides an ideal application for evaluating this proximity-outcome hypothesis. Previous studies have encountered empirical difficulties relating to potential endogenous health-based spatial sorting of involved agents and data limitations on out-of-hospital mortality. Using policy-induced variation in hospital distance arising from emergency room closures in the highly regulated Swedish health care sector and data on all AMI deaths in Sweden over two decades, estimation results show a clear and gradually declining probability of surviving an AMI as residential distance from an emergency room increases. The results further show that spatial sorting is likely to significantly attenuate the distance effect unless accounted for.

Baier, N., Geissler, A., Bech, M., et al. (2019). "Emergency and urgent care systems in Australia, Denmark, England, France, Germany and the Netherlands - Analyzing organization, payment and reforms." Health Policy 123(1) : 1-10.

INTRODUCTION: Increasing numbers of hospital emergency department (ED) visits pose a challenge to health systems in many countries. This paper aims to examine emergency and urgent care systems, in six countries and to identify reform trends in response to current challenges. METHODS: Based on a literature review, six countries - Australia, Denmark, England, France, Germany and the Netherlands - were selected for analysis. Information was collected using a standardized questionnaire that was completed by national experts. These experts reviewed relevant policy documents and provided information on (1) the organization and planning of emergency and urgent care, (2) payment systems for EDs and urgent primary care providers, and (3) reform initiatives. RESULTS: In the six countries four main reform approaches could be identified: (a) extending the availability of urgent primary care, (b) concentrating and centralizing the provision of urgent primary care, (c) improving coordination between urgent primary care and emergency care, and (d) concentrating emergency care provision at fewer institutions. The design of payment systems for urgent primary care and for emergency care is often aligned to support these reforms. CONCLUSION: Better guidance of patients and a reconfiguration of emergency and urgent

care are the most important measures taken to address the current challenges. Nationwide planning of all emergency care providers, closely coordinated reforms and informing patients can support future reforms.

Bardsley, M., Steventon, A., Smith, J., et al. (2013). Evaluating integrated and community-based care. How do we know what works ? Londres The Nuffield Trust
https://www.nuffieldtrust.org.uk/files/2017-01/evaluating-integrated-community-care-web-final.pdf

The Nuffield Trust has undertaken evaluations of over 30 community-based interventions designed to reduce emergency hospital admissions. This report presents the key learning from these studies.

Batal, H., Tench, J., McMillan, S., et al. (2001). "Predicting patient visits to an urgent care clinic using calendar variables." Acad Emerg Med 8(1) : 48-53.

OBJECTIVE: To develop a prediction equation for the number of patients seeking urgent care. METHODS: In the first phase, daily patient volume from February 1998 to January 1999 was matched with calendar and weather variables, and stepwise linear regression analysis was performed. This model was used to match staffing to patient volume. The effects were measured through patient complaint and "left without being seen" rates. The second phase was undertaken to develop a model to account for the continual yearly increase in patient volume. For this phase daily patient volume from February 1998 to April 2000 was used; the patient volume from May 2000 to July 2000 was used as a validation set. RESULTS: First-phase prediction equation was: daily patient volume = 66.2 + 11.1 January + 4.56 winter + 47.2 Monday + 37.3 Tuesday + 35.6 Wednesday + 28.2 Thursday + 24.2 Friday + 7.96 Saturday + 10.1 day after a holiday. This equation accounted for 75.2% of daily patient volume ($p<0.01$). Inclusion of significant weather variables only minimally improved the predictive ability ($r(2) = 0.786$). The second-phase final model was: daily patient volume = 57.2 + 0.035 Newdate + 52.0 Monday + 44. 2 Tuesday + 39.2 Wednesday + 30.2 Thursday + 26.5 Friday + 10.9 Saturday + 12.2 February + 3.9 March, which accounted for 72.7% of the daily variation ($p<0.01$). The model predicted the patient volume in the validation set within +/-11%. When the first-phase model was used to predict patient volume and thus staffing, the percentage of patients who left without being seen decreased by 18. 5% and the number of patient complaints dropped by 30%. CONCLUSIONS: Use of a prediction equation allowed for improved accuracy in staffing patterns with associated improvement in measures of patient satisfaction.

Berchet, C. (2015). Emergency Care Services: Trends - Drivers and Interventions to Manage the Demand. OECD Health Working Papers ; 83. Paris OCDE

Emergency departments are the front line of health care systems and play a critical role in ensuring an efficient and high-quality response for patients in stress or crisis situations. A growing demand for emergency care might however reduce patients' satisfaction (through waiting times), increase health provider workload and adversely affect quality of care. This working paper begins with an overview of the trends in the volume of emergency department visits across 21 OECD countries. It then explores the main drivers of emergency department visits in hospital settings, paying attention to both demand and supply side determinants. Thereafter, national approaches instituted by countries to reduce the demand for emergency care and to guarantee a more efficient use of emergency resources are presented.

Berchet, C. et Nader, C. (2016). The organisation of out-of hours primary care in OECD countries. OECD Health Working Papers ; 89. Paris OCDE
http://www.oecd-ilibrary.org/social-issues-migration-health/the-organisation-of-out-of-hours-primary-care-in-oecd-countries_5jlr3czbqw23-en

Out-of-hours (OOH) services provide urgent primary care when primary care physician (PCP) offices are closed, most often from 5pm on weekdays and all day on weekends and holidays. Based on a policy survey (covering 27 OECD countries) and the existing literature, the working paper describes the current challenges associated with the organisation of OOH primary care and reviews the existing models of delivering OOH primary care. The paper pays particular attention to policies which have been pursued to improve access and quality of OOH primary care. Findings of the paper show that most OECD health systems report key challenges to provide OOH primary care in an accessible and safe way. These challenges relate to (i) PCPs' reluctance to practise due to high workload and insufficient remuneration; and (ii) geographical variations in access to OOH primary care within each health system. Together these challenges are leading sources of inappropriate hospital emergency department (ED) visits. Results also indicate that several models of OOH primary care exist alongside each other in the 27 OECD countries participating in the policy survey. Hospital EDs, rota groups and practice-based services remain the most common OOH arrangements, but there is a tendency to shift OOH primary care towards primary care centres and large-scale organisations known as general practice cooperatives (GPCs). A range of solutions have been implemented to improve access and quality of OOH primary care across OECD countries. These include providing organisational and financial support to PCPs; using other health care professionals (such as nurse practitioners), making OOH care participation compulsory, setting up a telephone triage system, using new technologies, and developing rich information systems (résumé des auteurs)

Booth, A., Preston, L., Baxter, S., et al. (2019). Health Services and Delivery Research. Interventions to manage use of the emergency and urgent care system by people from vulnerable groups: a mapping review. Southampton (UK), NIHR Journals Library

BACKGROUND: The NHS currently faces increasing demands on accident and emergency departments. Concern has been expressed regarding whether the needs of vulnerable groups are being handled appropriately or whether alternative methods of service delivery may provide more appropriate emergency and urgent care services for particular groups. OBJECTIVE: Our objective was to identify what interventions exist to manage use of the emergency and urgent care system by people from a prespecified list of vulnerable groups. We aimed to describe the characteristics of these interventions and examine service delivery outcomes (for patients and the health service) resulting from these interventions. REVIEW METHODS: We conducted an initial mapping review to assess the quantity and nature of the published research evidence relating to seven vulnerable groups (socioeconomically deprived people and families, migrants, ethnic minority groups, the long-term unemployed/inactive, people with unstable housing situations, people living in rural/isolated areas and people with substance abuse disorders). Databases, including MEDLINE and the Cumulative Index to Nursing and Allied Health Literature, and other sources were searched between 2008 and 2018. Quantitative and qualitative systematic reviews and primary studies of any design were eligible for inclusion. In addition, we searched for UK interventions and initiatives by examining press reports, commissioning plans and casebooks of 'good practice'. We carried out a detailed intervention analysis, using an adapted version of the TIDieR (Template for Intervention Description and Replication) framework for describing interventions, and an

analysis of current NHS practice initiatives. RESULTS: We identified nine different types of interventions: care navigators [three studies - moderate GRADE (Grading of Recommendations, Assessment, Development and Evaluations)], care planning (three studies - high), case finding (five studies - moderate), case management (four studies - high), front of accident and emergency general practice/front-door streaming model (one study - low), migrant support programme (one study - low), outreach services and teams (two studies - moderate), rapid access doctor/paramedic/urgent visiting services (one study - low) and urgent care clinics (one systematic review - moderate). Few interventions had been targeted at vulnerable populations; instead, they represented general population interventions or were targeted at frequent attenders (who may or may not be from vulnerable groups). Interventions supported by robust evidence (care navigators, care planning, case finding, case management, outreach services and teams, and urgent care clinics) demonstrated an effect on the general population, rather than specific population effects. Many programmes mixed intervention components (e.g. case finding, case management and care navigators), making it difficult to isolate the effect of any single component. Promising UK initiatives (front of accident and emergency general practice/front-door streaming model, migrant support programmes and rapid access doctor/paramedic/urgent visiting services) lacked rigorous evaluation. Evaluation should therefore focus on the clinical effectiveness and cost-effectiveness of these initiatives. CONCLUSIONS: The review identified a limited number of intervention types that may be useful in addressing the needs of specific vulnerable populations, with little evidence specifically relating to these groups. The evidence highlights that vulnerable populations encompass different subgroups with potentially differing needs, and also that interventions seem particularly context sensitive. This indicates a need for a greater understanding of potential drivers for varying groups in specific localities. LIMITATIONS: Resources did not allow exhaustive identification of all UK initiatives; the examples cited are indicative. FUTURE WORK: Research is required to examine how specific vulnerable populations differentially benefit from specific types of alternative service provision. Further exploration, using primary mixed-methods data and potentially realist evaluation, is required to explore what works for whom under what circumstances. Rigorous evaluation of UK initiatives is required, including a specific need for economic evaluations and for studies that incorporate effects on the wider emergency and urgent care system. FUNDING: The National Institute for Health Research Health Services and Delivery Research programme.

Buja, A., Toffanin, R., Rigon, S., et al. (2015). "What determines frequent attendance at out-of-hours primary care services?" Eur J Public Health 25(4) : 563-568.

BACKGROUND: A detailed description of the characteristics of frequent attenders (FAs) at primary care services is needed to devise measures to contain the phenomenon. The aim of this population-registry-based research was to sketch an overall picture of the determinants of frequent attendance at out-of-hours (OOH) services, considering patients' clinical conditions and socio-demographic features, and whether the way patients' genaral practitioners (GPs) were organized influenced their likelihood of being FAs. METHODS: This study was a retrospective cohort study on electronic population-based records. The dataset included all OOH primary care service contacts from 1 January to 31 December 2011, linked with the mortality registry and with patients' exemption from health care charges. A FA was defined as a patient who contacted the service three or more times in 12 months. A logistic regression model was constructed to identify independent variables associated with this outcome. RESULTS: Multivariate analysis showed that not only frailty and clinical variables such as psychiatric disease are associated with FA status, but also socio-demographic

variables such as sex, age and income level. Alongside other environmental factors, the GP's gender and mode of collaboration in the provision of health services were also associated with OOH FA. CONCLUSION: Our study demonstrates that the determinants of OOH FA include not only patients' clinical conditions, but also several socio-economic characteristics (including income level) and their GPs' organizational format.

Buja, A., Toffanin, R., Rigon, S., et al. (2015). "Out-of-hours primary care services: Demands and patient referral patterns in a Veneto region (Italy) Local Health Authority." Health Policy 119(4) : 437-446.
http://www.healthpolicyjrnl.com/article/S0168-8510(15)00004-4/abstract

PURPOSE: The aim of this study was to describe the characteristics of patients admitted to an out-of-hours (OOH) service and to analyze the related outputs. SETTING: A retrospective population-based cohort study was conducted by analyzing an electronic database recording 23,980 OOH service contacts in 2011 at a Local Health Authority in the Veneto Region (North-East Italy). METHOD: A multinomial logistic regression was used to compare the characteristics of contacts handled by the OOH physicians with cases referred to other services. RESULTS: OOH service contact rates were higher for the oldest and youngest age groups and for females rather than males. More than half of the contacts concerned patients who were seen by a OOH physician. More than one in three contacts related problems managed over the phone; only approximately 10% of the patients were referred to other services. Many factors, including demographic variables, process-logistic variables and clinical characteristics of the contact, were associated with the decision to visit the patient's home (rather than provide telephone advice alone), or to refer patients to an ED or to a specialist. Our study demonstrated, even after adjusting, certain OOH physicians were more likely than their colleagues to refer a patient to an ED. CONCLUSION: Our study shows that OOH services meet composite and variously expressed demands. The determining factors associated with cases referred to other health care services should be considered when designing clinical pathways in order to ensure a continuity of care. The unwarranted variability in OOH physicians' performance needs to be addressed.

Bunn, J. G. et Croft, S. J. (2019). "Urgent care axis for the older adult: where is best to target interventions?" 36(1) : 22-26.

BACKGROUND: We explored the urgent care axis across EDs in Yorkshire and Humber (Y&H) for patients aged >/=75 years to identify where interventions could be targeted to prevent ED attendances and inpatient admissions. METHODS: Hospital Episode Statistics (HES) data for attendances across 18 EDs in Y&H from April 2011 to March 2014 were retrospectively analysed. HES A&E and Admitted Patient Care patient records data were linked to describe the entire patient pathway. The population studied was adult patients attending type 1 EDs, comparing those >/=75 years with those under 75. Data analysed included arrival mode, presentation time, time in ED, outcome (admitted/discharged), admission length of stay, International Classification of Diseases 10th Revision (ICD-10) and cause codes related to admission. Short-stay admissions and admissions with potentially avoidable conditions (identified by ICD-10 codes and cause codes) were identified. Comparative analysis was undertaken between sites. RESULTS: There were 3 736 541 ED attendances, of which 625 772 (16.7%) were >/=75 years. Older patients were significantly more likely to attend via ambulance than the younger cohort (OR 7.7, 95% CI 7.6 to 7.7), and had significantly longer median stays within ED (195 vs 136 min, p<0.001) and increased likelihood of admission (OR 4.5, 95% CI 4.5 to 4.6). Short-stay admissions accounted for 28.3% of older adult admissions.

37.3% of older adult admissions were with conditions that were potentially avoidable, accounting for 42.3% of short-stay admissions. There was regional variation in the proportions of older adults admitted (between 34.3% and 40.9%). DISCUSSION: Large numbers of older adults present to EDs mainly by ambulance. Significant proportions are admitted for short periods with conditions that might potentially be managed outside of hospital. Variation across the region warrants further study.

Buswell, J. (2013). "Emergency and urgent care." Nurs Older People 25(1) : 12.

Carlson, L. C., Raja, A. S., Dworkis, D. A., et al. (2020). "Impact of Urgent Care Openings on Emergency Department Visits to Two Academic Medical Centers Within an Integrated Health Care System." Ann Emerg Med 75(3) : 382-391.

STUDY OBJECTIVE: The effect of urgent cares on local emergency department (ED) patient volumes is presently unknown. In this paper, we aimed to assess the change in low-acuity ED utilization at 2 academic medical centers in relation to patient proximity to an affiliated urgent care. METHODS: We created a geospatial database of ED visits occurring between April 2016 and March 2018 to 2 academic medical centers in an integrated health care system, geocoded by patient home address. We used logistic regression to characterize the relationship between the likelihood of patients visiting the ED for a low-acuity condition, based on ED discharge diagnosis, and urgent care center proximity, defined as living within 1 mile of an open urgent care center, for each of the academic medical centers in the system, adjusting for spatial, temporal, and patient factors. RESULTS: We identified a statistically significant reduction in the likelihood of ED visits for low-acuity conditions by patients living within 1 mile of an urgent care center at 1 of the 2 academic medical centers, with an adjusted odds ratio of 0.87 (95% confidence interval 0.78 to 0.98). There was, however, no statistically significant reduction at the other affiliated academic medical center. Further analysis showed a statistically significant temporal relationship between time since urgent care center opening and likelihood of a low-acuity ED visit, with approximately a 1% decrease in the odds of a low-acuity visit for every month that the proximal urgent care center was open (odds ratio 0.99; 95% confidence interval 0.985 to 0.997). CONCLUSION: Although further research is needed to assess the factors driving urgent care centers' variable influence on low-acuity ED use, these findings suggest that in similar settings urgent care center development may be an effective strategy for health systems hoping to decrease ED utilization for low-acuity conditions at academic medical centers.

Carson, D., Clay, H. et Stern, R. (2010). Primary Care and Emergency Departments. Londres Primary Care Foundation.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1694659/pdf/amjph00527-0070.pdf

The Primary Care Foundation was commissioned by the UK Department of Health in May 2009 to carry out a study across England of the different models of primary care operating within or alongside emergency departments. The aim was to provide a viable estimate of the number of patients who attend emergency department with conditions that could be dealt with elsewhere in primary care

Carson, D., Clay, H. et Stern, R. (2012). Urgent Care Centres: What works best. Londres Primary Care Foundation
http://primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf

Clinical commissioning groups are in many places looking at how to provide the government?s vision of integrated urgent and emergency care while at the same time NHS 111 services are being launched. They are doing it against a backdrop of the need to contain cost and considerable attention is given to driving down attendance at emergency departments (EDs), while meeting the rising expectations of the public. Urgent care centres of various types have evolved as a way of meeting these needs. But we found little published evidence that they reduce attendances at A&E and some suggestion that they might increase the total burden on the NHS. Certainly many are meeting primary care needs (though some count these cases as urgent) and they are now firmly established. Many have the loyal support of local users who rally to defend their local centre when commissioners attempt to replace it. This discussion paper looks at the different models for providing urgent care services and evaluates their impact. Through site visits to 15 urgent care centres (UCCs) and a literature review carried out by Warwick Medical School as well as the support of a reference group we identified some criteria that we believe define a good service, one that delivers high quality, clinically appropriate and cost-effective care.

CEE (2008). Quality in and Equality of Access to Healthcare Services. Bruxelles Commission européenne
http://www.euro.centre.org/data/1237457784_41597.pdf

This study reviews barriers of access to health care that persist in European Union countries and presents an analysis of what policies countries have adopted to mitigate these barriers. It has a focus on the situation of migrants, older people with functional limitations, and people with mental disorders. What are the barriers to accessing high quality health care for people at risk of social exclusion? What are the interdependencies between poverty, social exclusion and problems of accessing health care? What policies have EU Member States put in place to improve access and quality of health care for vulnerable groups of the population? The study is based on eight country reports: Finland, Germany, Greece, the Netherlands, Poland, Romania, Spain, and the United Kingdom. This was complemented with findings from the literature and European comparisons. Ensuring equitable access to high-quality healthcare constitutes a key challenge for health systems throughout Europe. Despite differences in health system size, structure and financing, evidence suggests that across Europe particular sections of the population are disproportionately affected by barriers to accessing healthcare. Studies have also shown that difficulties in accessing healthcare are compounded by poverty and social exclusion, and that poverty and social exclusion compound difficulties in accessing healthcare.

Chen, C. E., Chen, C. T., Hu, J., et al. (2017). "Walk-in clinics versus physician offices and emergency rooms for urgent care and chronic disease management." Cochrane Database Syst Rev 2 : Cd011774.

BACKGROUND: Walk-in clinics are growing in popularity around the world as a substitute for traditional medical care delivered in physician offices and emergency rooms, but their clinical efficacy is unclear. OBJECTIVES: To assess the quality of care and patient satisfaction of walk-in clinics compared to that of traditional physician offices and emergency rooms for people who present with basic medical complaints for either acute or chronic issues. SEARCH METHODS: We searched CENTRAL, MEDLINE, Embase, six other databases, and two trials registers on 22 March 2016 together with reference checking, citation searching, and contact with study authors to identify additional studies. We applied no restrictions on language, publication type, or publication year. SELECTION CRITERIA: Study design: randomized trials,

non-randomized trials, and controlled before-after studies. POPULATION: standalone physical clinics not requiring advance appointments or registration, that provided basic medical care without expectation of follow-up. Comparisons: traditional primary care practices or emergency rooms. DATA COLLECTION AND ANALYSIS: We used standard methodological procedures expected by Cochrane and the Cochrane Effective Practice and Organisation of Care (EPOC) Group. MAIN RESULTS: The literature search identified 6587 citations, of which we considered 65 to be potentially relevant. We reviewed the abstracts of all 65 potentially relevant studies and retrieved the full texts of 12 articles thought to fit our study criteria. However, following independent author assessment of the full texts, we excluded all 12 articles. AUTHORS' CONCLUSIONS: Controlled trial evidence about the mortality, morbidity, quality of care, and patient satisfaction of walk-in clinics is currently not available.

CIHI (2005). Understanding emergency department wait times : Who is using emergency departments and how long are they waiting ? Ottawa CIHI

Poll after poll shows that timely access to care is a high priority for Canadians, for patients, health care providers and the public at large. Despite this, little information exists about waiting for care in emergency departments (EDs), including how long people wait and how wait times vary by patient and system characteristics. A new series of three reports from CIHI provides Canadians with some new information on some of the key issues regarding wait times in EDs.

Coates, V. E., McCann, A., Posner, N., et al. (2015). "'Well, who do I phone?' Preparing for urgent care: a challenge for patients and service providers alike'." J Clin Nurs 24(15-16) : 2152-2163.

AIMS AND OBJECTIVES: To investigate factors influencing patients' self-management of urgent diabetes problems that precipitated unscheduled hospital care. BACKGROUND: Diabetes is placing increasing resource demands on health services and current policy advocates management in primary care and community settings whenever possible. Such policy has implications for patient education and empowerment and on mechanisms within primary and community care to support the management of diabetes when urgent healthcare problems arise. DESIGN: Qualitative, descriptive investigation, across two contrasting sites. METHODS: Forty-five people admitted to hospital for urgent/emergency care due to diabetes-related problems were recruited from urban and rural localities in the UK. Semi-structured interviews were conducted and data analysed using nvivo version 8 and framework techniques. RESULTS: Self-management of diabetes was typically habitual, and urgent problems that proved difficult to resolve necessitated recourse to unscheduled hospital care. Though skills relating to problem-solving, decision-making, resource use and formation of patient-provider partnerships were evident among some participants, these required further development. Evidence of action planning or self-tailoring skills was sparse. CONCLUSIONS: Education plays an important role in assisting individuals to self-manage their diabetes on a daily basis, but urgent, unexpected health problems proved challenging for both patients and health service providers. A greater focus on empowering patients with core self-management skills is required to enhance ability to successfully manage unexpected diabetes complications, coupled with enhanced primary care resources, particularly out-of-hours. RELEVANCE TO CLINICAL PRACTICE: The importance of informal and structured diabetes education should not be underestimated; however, the challenge of improving skills such as problem-solving to manage urgent healthcare needs must be tackled. This study provokes debate regarding how best to deliver appropriate education and health services to

cover urgent unscheduled care needs without automatically referring to emergency department hospital care.

Coleman, P. et Nicholl, J. (2010). "Consensus methods to identify a set of potential performance indicators for systems of emergency and urgent care." J Health Serv Res Policy 15 Suppl 2 : 12-18.

OBJECTIVES: To identify a comprehensive set of indicators to enable Primary Care Trust (PCT) commissioners in England and other NHS decision-makers to monitor the performance of systems of emergency and urgent care for which they are responsible. METHODS: Using a combination of Delphi RAND methods in three successive rounds of consultation and nominal group review, we canvassed expert opinion on 70 potential indicators as good measures of system performance. The two Delphi panels consisted of senior clinicians and researchers, and urgent care leads and commissioners in PCTs and Strategic Health Authorities (SHAs). The indicators were formatted into a questionnaire according to whether they were outcome, process, structure, or equity-based measures. Participants scored each indicator on a Likert scale of 1-9 and had the opportunity to consider their scores informed by the group scores and feedback. The questionnaire was refined after each round. To ensure that the indicators rated most highly by the Delphi panels covered all dimensions of performance, the results of the Delphi were reviewed by a nominal group consisting of two researchers and three clinicians from the local health services research network (LHSR). RESULTS: Overall, the process yielded 16 candidate indicators. It also produced a core set of serious, emergency and urgent care-sensitive conditions (defined as conditions whose exacerbations should be managed by a well-performing system without admission to an inpatient bed), for use with the indicators. CONCLUSIONS: System-wide measures to monitor performance across multiple services should encourage providers to work for patient benefit in an integrated way. They will also assist commissioners to monitor and improve emergency and urgent care for their local populations. The indicators are now being calculated using routinely available data, and tested for their responsiveness to capture change over time.

Conroy, S. (2019). "The Acute Frailty Network - supporting people with frailty and urgent care needs to get home sooner and healthier." JMIR Res Protoc 6(Suppl 1) : 109.

Conroy, S. et Chikura, G. (2015). "Emergency care for frail older people—urgent AND important—but what works?" Age and Ageing 44(5) : 724-725.
http://ageing.oxfordjournals.org/content/44/5/724.short

Conroy, S. P. et Turpin, S. (2016). "New horizons: urgent care for older people with frailty." Age Ageing 45(5) : 577-584.

Urgent care for older people is a major public health issue and attracts much policy attention. Despite many efforts to curb demand, many older people with frailty and urgent care needs to access acute hospital services. The predominant model of care delivered in acute hospitals tends to be medically focussed, yet the evidence-based approaches that appear to be effective invoke a holistic model of care, delivered by interdisciplinary teams embedding geriatric competencies into their service. This article reviews the role for holistic care-termed Comprehensive Geriatric Assessment in the research literature-and how it can be used as an organising framework to guide future iterations of acute services to be better able to meet the multifaceted needs of older people.

Cooper, Z., Scott Morton, F. et Shekita, N. (2017). Surprise! Out-of-Network Billing for Emergency Care in the United States. NBER Working Paper Series ; n° 23623. Cambridge NBER http://www.nber.org/papers/w23623

Using insurance claims data, we show that in 22% of emergency episodes, patients attended in-network hospitals, but were treated by out-of-network physicians. Out-of-network billing allows physicians to significantly increase their payment rates relative to what they would be paid for treating in-network patients. Because patients cannot avoid out-of-network physicians during an emergency, physicians have an incentive to remain out-of-network and receive higher payment rates. Hospitals incur costs when out-of-network billing occurs within their facilities. We illustrate in a model and confirm empirically via analysis of two leading physician-outsourcing firms that physicians offer transfers to hospitals to offset the costs of out-of-network billing and allow the practice to continue. We find that a New York State law that introduced binding arbitration between physicians and insurers to settle surprise bills reduced out-of-network billing rates.

Cowling, T. E., Ramzan, F., Ladbrooke, T., et al. (2016). "Referral outcomes of attendances at general practitioner led urgent care centres in London, England: retrospective analysis of hospital administrative data." Emerg Med J 33(3) : 200-207.

OBJECTIVE: To identify patient and attendance characteristics that are associated with onwards referral to co-located emergency departments (EDs) or other hospital specialty departments from general practitioner (GP) led urgent care centres (UCCs) in northwest London, England. METHODS: We conducted a retrospective analysis of administrative data recorded in the UCCs at Charing Cross and Hammersmith Hospitals, in northwest London, from October 2009 to December 2012. Attendances made by adults resident in England were included. Logistic regression was used to model the associations between the explanatory variables-age; sex; ethnicity; socioeconomic status; area of residence; distance to UCC; GP registration; time, day, quarter, year; and UCC of attendance-and the outcome of onwards referral to the co-located EDs or other hospital specialty departments. RESULTS: Of 243 042 included attendances, 74.1% were managed solely within the UCCs without same day referral to the EDs (16.8%) or other hospital specialty departments (5.7%), or deferred referral to a fracture, hand management or soft tissue injury management clinic (3.3%). The adjusted odds of onwards referral was estimated to increase by 19% (OR 1.19, 95% CI 1.18 to 1.19) for a 10 year increase in a patient's age. Men, patients registered with a GP and residents of less socioeconomically deprived areas were also more likely to be referred onwards from the UCCs. CONCLUSIONS: The majority of patients, across each category of all explanatory variables, were managed solely within the UCCs, although a large absolute number of patients were referred onwards each year. Several characteristics of patients and their attendances were associated with the outcome variable.

Cremonesi, P., di Bella, E., Montefiori, M., et al. (2015). "The Robustness and Effectiveness of the Triage System at Times of Overcrowding and the Extra Costs due to Inappropriate Use of Emergency Departments." Appl Health Econ Health Policy 13(5) : 507-514.

BACKGROUND: Overcrowding is one of the most harmful problems for Emergency Department (ED) management and the correct estimation of time resource absorption by each type of patient plays a strategic role in dealing with overcrowding and correctly programming ED activity. OBJECTIVE: We aimed to investigate how overcrowding may affect urgent patients' waiting times (i.e., the robustness of the triage patient priority system) and

to evaluate the extra costs due to inappropriate use of EDs. METHODS: Data referring to 54,254 patients who accessed the ED of a major Italian hospital in 2011 were analyzed to study patient flows and overcrowding. To define an average per-patient cost, according to the severity of his or her health condition, the 2010 profit and loss account of the aforementioned hospital was studied and the time devoted by physicians to each type of patient was estimated by means of a self-reported survey. RESULTS: Empirical findings confirm a positive correlation between overcrowding and the time a patient has to wait before receiving treatment. This effect is relevant only for non-urgent patients who are responsible for the overcrowding itself. However, urgent patients' waiting times do not increase in the presence of overcrowding, confirming that the triage priority system is robust against the overcrowding situation. The analysis estimates, using 2010 data, that the actual per patient cost incurred by the hospital when treating white-coded patients is, on average, 36.54 euros; a green code costs 93.17, yellow 170.62, and red 227.62. It emerges that 4 % of all the personnel costs are attributable to white color-code assistance, 67 % to green codes, 23 % to yellow codes, and the remaining 6 % to red codes. CONCLUSION: The implementation of effective policies intended to improve both efficiency and quality in providing emergency health services has to deal with the systemic problem of inappropriate use of EDs. Policy-makers should be aware of the fact that there is a considerable portion of ED demand for assistance that is inappropriate and that oversizing EDs with respect to the true, appropriate, urgent patients' demands, could bring about a further and undesirable rise in inappropriate assistance demands and, therefore, an increase in ED costs that are not consistent with their objectives.

Dale, J., Russell, R., Harkness, F., et al. (2017). "Extended training to prepare GPs for future workforce needs: A qualitative investigation of a 1-year fellowship in urgent care." Br J Gen Pract 67(662) : e659-e667.

BACKGROUND: It has been argued that UK general practice specialist training should be extended to better prepare GPs for the challenges facing 21st-century health care. Evidence is needed to inform how this should occur. AIM: To investigate the experience of recently trained GPs undertaking a 1-year full-time fellowship programme designed to provide advanced skills training in urgent care, integrated care, leadership, and academic practice; and its impact on subsequent career development. DESIGN AND SETTING: Semi-structured interviews conducted longitudinally over 2 years augmented by observational data in the West Midlands, England. METHOD: Participants were interviewed on at least three occasions: twice while undertaking the fellowship, and at least once post-completion. Participants' clinical and academic activities were observed. Data were analysed using a framework approach. RESULTS: Seven GPs participated in the pilot scheme. The fellowship was highly rated and felt to be balanced in terms of the opportunities for skill development, academic advancement, and confidence building. GPs experienced enhanced employability on completing the scheme, and at follow-up were working in a variety of primary care/urgent care interface clinical and leadership roles. Participants believed it was making general practice a more attractive career option for newly qualified doctors. CONCLUSION: The 1-year fellowship provides a defined framework for training GPs to work in an enhanced manner across organisational interfaces with the skills to support service improvement and integration. It appears to be well suited to preparing GPs for portfolio roles, but its wider applicability and impact on NHS service delivery needs further investigation.

Dautel, M. M., Montserrat, X. et De Rezende, P. (2002). Etude comparée de l'organisation des services d'urgence dans dix pays européens. Paris Ministère chargé de la santé

Le présent rapport est le fruit d'un travail mené par la Direction de l'Hospitalisation et de l'Organisation des Soins, avec l'appui d'établissements hospitaliers français et européens, le réseau de Conseillers Sociaux du Ministère de la Santé français et les administrations sanitaires européennes. Répondant à un besoin d'information et d'expertise, ce rapport a pour objet de présenter une analyse comparée de l'organisation des services d'urgences dans 10 pays de la Communauté européenne sous un double aspect : faire un état des lieux et repérer les leviers d'action qui pourraient être éventuellement utilisés pour répondre aux objectifs français d'une meilleure organisation des urgences.

Davidson, M. B., Ansari, A. et Karlan, V. J. (2007). "Effect of a nurse-directed diabetes disease management program on urgent care/emergency room visits and hospitalizations in a minority population." Diabetes Care 30(2) : 224-227.

OBJECTIVE: To evaluate whether nurse-directed diabetes care reduced preventable diabetes-related urgent care/emergency room visits and hospitalizations in a minority population. RESEARCH DESIGN AND METHODS: Diabetic patients who receive care in a county public health clinic were randomly selected for a Diabetes Managed Care Program (DMCP) in which a specially trained nurse followed detailed treatment algorithms to provide diabetes care for 1 year. Preventable diabetes-related urgent care/emergency room visits and hospitalizations for these patients incurred during the intervention year and the year before enrollment were compared. Preventable diabetes-related causes were defined as metabolic (diabetic ketoacidosis, hyperglycemia, or hypoglycemia) or infection (cellulitis, foot ulcer, osteomyelitis, fungal infection, or urinary tract infection). RESULTS: Use of the urgent care/emergency room and hospitalizations during the intervention year and the year prior were available for 331 patients who completed the DMCP intervention. There were 95 [corrected] total urgent care/emergency room visits and hospitalizations in the year before entering the DMCP and 52 [corrected] during the DMCP year, a 45[corrected]% reduction. Preventable diabetes-related episodes were far fewer. During the prior year, 14 patients made 15 urgent care/emergency room visits and 5 patients incurred 6 hospitalizations. During the DMCP year, four different patients made five emergency room/urgent care visits and one other patient was hospitalized. Preventable diabetes-related use was significantly ($P < 0.001$) lower during the intervention year compared with the prior year. Total charges for urgent care/emergency room visits and hospitalizations only (not other charges related to diabetes care) during the year before entering the DMCP were $129,176 compared with $24,630 during the DMCP year. CONCLUSIONS: When compared with usual care, nurse-directed diabetes care resulted in significantly fewer urgent care/emergency room visits and hospitalizations for preventable diabetes-related causes. Policy makers seeking to improve diabetes care and conserve resources should seriously consider adopting this approach.

Di Pollina, L., Guessous, I. et Petoud, V. (2017). "Integrated care at home reduces unnecessary hospitalizations of community-dwelling frail older adults: a prospective controlled trial." Bmc Geriatrics 17(53)
http://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-017-0449-9

We conducted a prospective controlled study performed in real-life clinical practice settings to evaluate the efficacy of formally coordinating existing resources: 2 home visiting nursing service centers (HVNS) and a community geriatric unit (CGU) that included a physician to perform in-home multidimensional geriatric assessment, and a 24h/ 7 days a week call service for frail older adults. We hypothesized that this approach could decrease the number

of hospitalizations, decrease or delay unnecessary hospitalizations, emergency room visits, and institutionalization, as well as increase the probability of respecting care goals of patients with advanced illness who wish to remain at home.

Donatini, A., Fiorentini, G., Lippi Bruni, I. et al. (2014). Dealing with minor illnesses: the link between primary care characteristics and First Aid Clinics' attendances. Quaderni Working Paper DSE ; 925. Bologne University of Bologna

The reformulation of existing boundaries between primary and secondary care, in order to shift selected services traditionally provided by Emergency Departments to community-based alternatives has determined a variety of organisational solutions aimed at reducing the ED overcrowding. One innovative change has been the introduction of fast-track systems for minor injuries or illnesses, whereby community care providers are involved in order to divert patients away from EDs. These facilities offer an open-access service for patients not requiring hospital treatments, and may be staffed by nurses and/or primary care general practitioners operating within, or alongside, the ED. To date little research has been undertaken on such experiences. To fill this gap, this study analyses a First-aid clinic (FaC) in the Italian city of Parma, consisting of a minor injury unit located alongside the teaching hospital's ED. It examines the link between the utilisation rates of the FaC and primary care characteristics, focusing on the main organisational features of the practices and estimating panel count data models for 2007-2010. Its main findings indicate that the younger cohorts are heavy users of the FaC and that the extension of practice opening hours significantly lowers the number of attendances, after controlling for GP's and practice's characteristics.

Drummond, N., McConnachie, A., O'Donnell, C. A., et al. (2000). "Social variation in reasons for contacting general practice out-of-hours: implications for daytime service provision?" British Journal of General Practice 50(455) : 460-464.

Eiting, E., Korn, C. S., Wilkes, E., et al. (2017). "Reduction in Jail Emergency Department Visits and Closure After Implementation of On-Site Urgent Care." J Correct Health Care 23(1) : 88-92.

This descriptive study evaluates the impact of implementation of full service on-site urgent care services at the Los Angeles County Jail (LACJ) by examining the number of patients seen at the referral hospital, Los Angeles County + University of Southern California Medical Center (LAC+USC), and the number of hours that the referral hospital was closed to transfers in the periods before and after the development of the LACJ Urgent Care. The appropriate utilization of public resources is a critical priority for an overburdened county medical health care system. Implementing on-site urgent care staffed by emergency physicians led to reductions in the average number of patients transferred to LAC+USC, the average number of monthly closure hours, and the average days per month when closure to transfer occurred, and a cost savings of some $2 million, primarily in personnel costs.

Eracleous, M., Muller, M., Srivastava, D. S., et al. (2018). "Physician assistants in urgent care." Int J Environ Res Public Health 31(8) : 40-44.

OBJECTIVE: To describe the characteristics of physician assistants (PAs) who practice urgent care. METHODS: Data from national surveys conducted by the American Academy of PAs (AAPA) between 1998 and 2016 were analyzed, comparing PAs who practice in urgent care, emergency medicine, and all other specialties. RESULTS: The percentage of PAs who work in an urgent care setting has nearly doubled in the last 10 years. PAs who work in urgent care

see more patients and perform more minor surgical procedures than those in emergency medicine. They are less likely to be newly graduated PAs than those in emergency medicine. PAs in urgent care are less likely than other PAs to consult a physician about their patients in real time. CONCLUSION: The number of PAs practicing urgent care is increasing. More research is needed to further characterize PA practice in this specialty.

Fontil, V. et Khoong, E. C. (2019). "Evaluation of a Health Information Technology-Enabled Collective Intelligence Platform to Improve Diagnosis in Primary Care and Urgent Care Settings: Protocol for a Pragmatic Randomized Controlled Trial." 8(8) : e13151.

BACKGROUND: Diagnostic error in ambulatory care, a frequent cause of preventable harm, may be mitigated using the collective intelligence of multiple clinicians. The National Academy of Medicine has identified enhanced clinician collaboration and digital tools as a means to improve the diagnostic process. OBJECTIVE: This study aims to assess the efficacy of a collective intelligence output to improve diagnostic confidence and accuracy in ambulatory care cases (from primary care and urgent care clinic visits) with diagnostic uncertainty. METHODS: This is a pragmatic randomized controlled trial of using collective intelligence in cases with diagnostic uncertainty from clinicians at primary care and urgent care clinics in 2 health care systems in San Francisco. Real-life cases, identified for having an element of diagnostic uncertainty, will be entered into a collective intelligence digital platform to acquire collective intelligence from at least 5 clinician contributors on the platform. Cases will be randomized to an intervention group (where clinicians will view the collective intelligence output) or control (where clinicians will not view the collective intelligence output). Clinicians will complete a postvisit questionnaire that assesses their diagnostic confidence for each case; in the intervention cases, clinicians will complete the questionnaire after reviewing the collective intelligence output for the case. Using logistic regression accounting for clinician clustering, we will compare the primary outcome of diagnostic confidence and the secondary outcome of time with diagnosis (the time it takes for a clinician to reach a diagnosis), for intervention versus control cases. We will also assess the usability and satisfaction with the digital tool using measures adapted from the Technology Acceptance Model and Net Promoter Score. RESULTS: We have recruited 32 out of our recruitment goal of 33 participants. This study is funded until May 2020 and is approved by the University of California San Francisco Institutional Review Board until January 2020. We have completed data collection as of June 2019 and will complete our proposed analysis by December 2019. CONCLUSIONS: This study will determine if the use of a digital platform for collective intelligence is acceptable, useful, and efficacious in improving diagnostic confidence and accuracy in outpatient cases with diagnostic uncertainty. If shown to be valuable in improving clinicians' diagnostic process, this type of digital tool may be one of the first innovations used for reducing diagnostic errors in outpatient care. The findings of this study may provide a path forward for improving the diagnostic process. INTERNATIONAL REGISTERED REPORT IDENTIFIER (IRRID): DERR1-10.2196/13151.

Fournier, J., Heale, R. et Rietze, L. (2012). ""I Can't Wait": Advanced Access Decreases Wait Times in Primary Healthcare." Healthcare Quarterly 15(1) : 64-68.

Research has shown that a strong primary healthcare system results in better health outcomes and lower costs (Starfield 1994). A key characteristic of a strong primary healthcare system is access to care. Two elements of a strong healthcare system are accessibility and short wait times for service. In Canada, a shortage of primary healthcare providers is the biggest obstacle to reducing wait times to primary healthcare services;

> however, timely access to one's primary healthcare provider is also a significant barrier (Howell 2008). Wait times to see primary care physicians are longer for Canadians than for patients in the United States, Australia and the United Kingdom (Bundy et al. 2005; College of Family Physicians of Canada 2006; Sanmartin and Ross 2006). Longer wait times are associated with patient dissatisfaction, poorer individual health outcomes and an increased use of emergency departments and urgent care clinics (Gupta and Denton 2008; Hill and Joonas 2005; Hudec et al. 2010; Valenti and Bookhardt-Murray 2004).

Garthwaite, C., Gross, T. et Notowidigdo, M. J. (2015). Hospitals as Insurers of Last Resort. NBER Working Paper Series ; n° 21290. Cambridge NBER
www.nber.org/papers/w21290

> American hospitals are required to provide emergency medical care to the uninsured. We use previously confidential hospital financial data to study the resulting uncompensated care, medical care for which no payment is received. We use both panel-data methods and case studies from state-wide Medicaid disenrollments and find that the uncompensated care costs of hospitals increase in response to the size of the uninsured population. The results suggest that each additional uninsured person costs local hospitals $900 each year in uncompensated care. Similarly, the closure of a nearby hospital increases the uncompensated care costs of remaining hospitals. Increases in the uninsured population also lower hospital profit margins, which suggests that hospitals cannot simply pass along all increased costs onto privately insured patients. For-profit hospitals are less affected by these factors, suggesting that non-profit hospitals serve a unique role as part of the social insurance system.

Gaugham, J., Kasteridis, P., Mason, A., et al. (2019). "Why are there long waits at English emergency departments?" European Journal of Health Economics (Ahead of print) : 1-10.
http://d.repec.org/n?u=RePEc:ehl:lserod:102571&r=hea

> A core performance target for the English National Health Service (NHS) concerns waiting times at Emergency Departments (EDs), with the aim of minimising long waits. We investigate the drivers of long waits. We analyse weekly data for all major EDs in England from April 2011 to March 2016. A Poisson model with ED fixed effects is used to explore the impact on long (> 4 h) waits of variations in demand (population need and patient case-mix) and supply (emergency physicians, introduction of a Minor Injury Unit (MIU), inpatient bed occupancy, delayed discharges and long-term care). We assess overall ED waits and waits on a trolley (gurney) before admission. We also investigate variation in performance among EDs. The rate of long overall waits is higher in EDs serving older patients (4.2%), where a higher proportion of attendees leave without being treated (15.1%), in EDs with a higher death rate (3.3%) and in those located in hospitals with greater bed occupancy (1.5%). These factors are also significantly associated with higher rates of long trolley waits. The introduction of a co-located MIU is significantly and positively associated with long overall waits, but not with trolley waits. There is substantial variation in waits among EDs that cannot be explained by observed demand and supply characteristics. The drivers of long waits are only partially understood but addressing them is likely to require a multi-faceted approach. EDs with high rates of unexplained long waits would repay further investigation to ascertain how they might improve.

Glasby, J., Littlechild, R., Le Mesurier, N., et al. (2016). Who knows best? Older people's contribution to understanding and preventing avoidable hospital admissions. Birmingham Health Services Management Centre **:** 64, tabl., fig.
http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2016/who-knows-best.pdf

The authors of this report interviewed 104 older people, exploring their experiences of emergency admissions. The research focused on whether the older people felt it was appropriate to be admitted to hospital and whether they thought anything could have prevented their admission. The findings of this study confirm the belief that older people have an important role to play in helping understand the nature of emergency admissions and to devise appropriate responses to their rising numbers. The report concludes that ignoring this expertise could be detrimental to ensuring older people get the appropriate care they need

Gnani, S., Ramzan, F., Ladbrooke, T., et al. (2013). "Evaluation of a general practitioner-led urgent care centre in an urban setting: description of service model and plan of analysis." JRSM Short Rep 4(6) : 2042533313486263.

Estimates of patients attending with conditions deemed non-urgent or inappropriate for accident and emergency services vary widely, from 6 to 80%. Previous research suggests that general practitioners (GPs) working in emergency departments can reduce referral rates, diagnostic testing, the proportion of patients who become emergency hospital admissions, and inappropriate attendances. However, little of this previous research is recent and new models of care for GPs working in emergency departments have now been developed, which remain to be evaluated. In this paper, we describe an integrated urgent care model, which was commissioned by NHS Hammersmith and Fulham in 2009 to manage the rising number of urgent attendances at local hospitals and its associated evaluation. The evaluation will include examining the effect of the system on outcomes such as utilization of diagnostic tests and effect on unplanned hospital admissions. If the new model of care is shown to be both clinically effective and cost-effective, the model and the proposed plan of evaluation will also be helpful to other areas that are considering the introduction of similar models of GP-led urgent care.

Goncalves-Bradley, D., Khangura, J. K., Flodgren, G., et al. (2018). "Primary care professionals providing non-urgent care in hospital emergency departments." Cochrane Database Syst Rev **2** : Cd002097.

BACKGROUND: In many countries emergency departments (EDs) are facing an increase in demand for services, long waits, and severe crowding. One response to mitigate overcrowding has been to provide primary care services alongside or within hospital EDs for patients with non-urgent problems. However, it is unknown how this impacts the quality of patient care and the utilisation of hospital resources, or if it is cost-effective. This is the first update of the original Cochrane Review published in 2012. OBJECTIVES: To assess the effects of locating primary care professionals in hospital EDs to provide care for patients with non-urgent health problems, compared with care provided by regularly scheduled emergency physicians (EPs). SEARCH METHODS: We searched the Cochrane Central Register of Controlled Trials (the Cochrane Library; 2017, Issue 4), MEDLINE, Embase, CINAHL, PsycINFO, and King's Fund, from inception until 10 May 2017. We searched ClinicalTrials.gov and the WHO ICTRP for registered clinical trials, and screened reference lists of included papers and

relevant systematic reviews. SELECTION CRITERIA: Randomised trials, non-randomised trials, controlled before-after studies, and interrupted time series studies that evaluated the effectiveness of introducing primary care professionals to hospital EDs attending to patients with non-urgent conditions, as compared to the care provided by regularly scheduled EPs. DATA COLLECTION AND ANALYSIS: We used standard methodological procedures expected by Cochrane. MAIN RESULTS: We identified four trials (one randomised trial and three non-randomised trials), one of which is newly identified in this update, involving a total of 11,463 patients, 16 general practitioners (GPs), 9 emergency nurse practitioners (NPs), and 69 EPs. These studies evaluated the effects of introducing GPs or emergency NPs to provide care to patients with non-urgent problems in the ED, as compared to EPs for outcomes such as resource use. The studies were conducted in Ireland, the UK, and Australia, and had an overall high or unclear risk of bias. The outcomes investigated were similar across studies, and there was considerable variation in the triage system used, the level of expertise and experience of the medical practitioners, and type of hospital (urban teaching, suburban community hospital). Main sources of funding were national or regional health authorities and a medical research funding body.There was high heterogeneity across studies, which precluded pooling data. It is uncertain whether the intervention reduces time from arrival to clinical assessment and treatment or total length of ED stay (1 study; 260 participants), admissions to hospital, diagnostic tests, treatments given, or consultations or referrals to hospital-based specialist (3 studies; 11,203 participants), as well as costs (2 studies; 9325 participants), as we assessed the evidence as being of very low-certainty for all outcomes.No data were reported on adverse events (such as ED returns and mortality). AUTHORS' CONCLUSIONS: We assessed the evidence from the four included studies as of very low-certainty overall, as the results are inconsistent and safety has not been examined. The evidence is insufficient to draw conclusions for practice or policy regarding the effectiveness and safety of care provided to non-urgent patients by GPs and NPs versus EPs in the ED to mitigate problems of overcrowding, wait times, and patient flow.

Gowrisankaran, G., Joiner, K. A. et Leger, P. T. (2017). Physician Practice Style and Healthcare Costs: Evidence from Emergency Departments. NBER Working Paper Series ; n° 24155. Cambridge NBER
http://papers.nber.org/papers/W24155

We examine the variation across emergency department (ED) physicians in their resource use and health outcomes, and the relationship between ED resource use and future healthcare costs and outcomes. Our data record the initial treating hospital, ED physician, ED billed expenditures, and all interactions with the provincial health system within the subsequent 90 days for EDs in Montreal, Canada. Physicians in Montreal rotate across shifts between simple and difficult cases, implying a quasi-random assignment of patients to physicians conditional on the choice of ED. We consider three medical conditions that present frequently in the ED and for which mistreatment can result in dramatic consequences: angina, appendicitis, and transient ischemic attacks. To control for variation across physicians in their diagnostic acumen, for each condition, our sample consists of patients with a broader set of symptoms and signs that could be indicative of the condition. We regress measures of healthcare costs on indicators for the hospital and ED physician separately by condition. We then evaluate the correlations between different measures of skill and resource use. We find strong positive correlations of physician resource use and skills across the three conditions. However, physicians with costly practice styles are often associated with worse outcomes, in terms of more ED revisits and more hospitalizations. One exception is that for patients in the angina sample, ED physicians with more spending have

fewer hospitalizations. Comparisons of physician effects for the base and broader sets of conditions show that both diagnosis and disposition skills are important.

Greenfield, G., van Gils-van Rooij, E. S. J., Meijboom, B. R., et al. (2018). "Is patient flow more efficient in Urgent Care Collaborations?" BMJ Open 25(1) : 58-64.

OBJECTIVE: Emergency Departments and out-of-hours General Practitioner services collaborate increasingly in Urgent Care Collaborations (UCCs) by sharing one combined entrance and joint triage. The aim of this study is to examine the difference between UCCs and providers who operate separately with respect to the efficiency of patient flow. METHODS: This study had a cross-sectional observational design comparing three regions with UCC with three regions with usual care. Outcome measures were efficiency of patient flow, defined as a reducing length of stay (LOS), waiting time (WT) and the mean number of handovers. Data were obtained from electronic medical records. RESULTS: LOS (median 34:00 vs. 38:52 min) and WT (median 14:00 vs. 18:43 min) were statistically significantly longer in UCCs compared with usual care. This difference is mainly explained by the prolonged LOS and WT for consulting a General Practitioner. The mean number of interunit handovers was larger in UCCs. CONCLUSION: The results indicate that, on average, UCCs do not enhance the efficiency of patient flow. The median LOS and WT are longer in UCCs and more handovers occur in UCCs compared with usual care.

Groom, N., Kidd, T. et Carey, N. (2018). "Urgent care centre redirection: evaluation of a nurse-led intervention." Emerg Nurse 25(9) : 25-30.

AIM: Patient redirection can help reduce service demand by providing information about more appropriate services. There is, however, no evidence about the effect of nurse-led patient redirection in urgent care centre settings. The aim of this project was to develop and evaluate a nurse-led patient 'self-care and redirection first' intervention in an urgent care centre (UCC). METHOD: Adopting a prospective observational design, the intervention was delivered to an opportunity sample of patients who attended a south London hospital UCC, between June and July 2014, and evaluated through patient interviews five to ten days after initial attendance. FINDINGS: 118 of the 1,710 people who attended the UCC participated in the intervention, of whom 81 (69%) were redirected to other services or home to self-care, and 37 were transferred to an emergency department. Of the 110 (93.2%) participants who completed the questionnaire, 97.2% were satisfied with the service. Only two accessed different services to those recommended, 72.2% (n =85) said they would not reattend a UCC for a similar condition. CONCLUSION: Treating minor ailments in a UCC is an inefficient use of resources. A nurse-led self-care and redirection intervention can help divert patients with minor ailments to more appropriate services. Further evaluation of the effect of the intervention on service demand and costs is required.

Gurganious, V. et Greenfield, D. (2015). "Starting an urgent care center. 5 essentials for success." Med Econ 92(11) : 47-48.

Hastings, S. N. et Heflin, M. T. (2005). "A Systematic Review of Interventions to Improve Outcomes for Elders Discharged from the Emergency Department." Academic Emergency Medicine 12(10) : 978-986.

To evaluate the evidence for interventions designed to improve outcomes for elders discharged from the emergency department (ED). The study was a systematic review of

English-language articles indexed in MEDLINE and CINAHL (1966-2005) with 1) key words "geriatric," "older adults," or "seniors," or 2) Medical Subject Heading (MeSH) terms "Geriatrics" or "Health Services for the Aged" AND key word "emergency," or 3) MeSH terms "Emergencies," "Emergency Service, Hospital," or "Emergency Treatment." Bibliographies of the retrieved articles were reviewed for additional references, and the authors consulted with content experts to identify relevant unpublished work. Patients of interest were community-dwelling elder patients discharged home from the ED. Data were abstracted from selected articles by the authors. Studies with interventions limited to patients with a single presentation or diagnosis (falls, delirium, etc.) or delivered only to patients who would have otherwise been hospitalized were not included.

Ho, V., Metcalfe, L., Dark, C., et al. (2017). "Comparing Utilization and Costs of Care in Freestanding Emergency Departments, Hospital Emergency Departments, and Urgent Care Centers." Ann Emerg Med 70(6) : 846-857.e843.

STUDY OBJECTIVE: We compare utilization, price per visit, and the types of care delivered across freestanding emergency departments (EDs), hospital-based EDs, and urgent care centers in Texas. METHODS: We analyzed insurance claims processed by Blue Cross Blue Shield of Texas from 2012 to 2015 for patient visits to freestanding EDs, hospital-based EDs, or urgent care centers in 16 Texas metropolitan statistical areas containing 84.1% of the state's population. We calculated the aggregate number of visits, average price per visit, proportion of price attributable to facility and physician services, and proportion of price billed to Blue Cross Blue Shield of Texas versus out of pocket, by facility type. Prices for the top 20 diagnoses and procedures by facility type are compared. RESULTS: Texans use hospital-based EDs and urgent care centers much more than freestanding EDs, but freestanding ED utilization increased 236% between 2012 and 2015. The average price per visit was lower for freestanding EDs versus hospital-based EDs in 2012 ($1,431 versus $1,842), but prices in 2015 were comparable ($2,199 versus $2,259). Prices for urgent care centers were only $164 and $168 in 2012 and 2015. Out-of-pocket liability for consumers for all these facilities increased slightly from 2012 to 2015. There was 75% overlap in the 20 most common diagnoses at freestanding EDs versus urgent care centers and 60% overlap for hospital-based EDs and urgent care centers. However, prices for patients with the same diagnosis were on average almost 10 times higher at freestanding and hospital-based EDs relative to urgent care centers. CONCLUSION: Utilization of freestanding EDs is rapidly expanding in Texas. Higher prices at freestanding and hospital-based EDs relative to urgent care centers, despite substantial overlap in services delivered, imply potential inefficient use of emergency facilities.

Hong, R., Sexton, R., Sweet, B., et al. (2015). "Comparison of START triage categories to emergency department triage levels to determine need for urgent care and to predict hospitalization." Am J Disaster Med 10(1) : 13-21.

OBJECTIVE: To compare Emergency Severity Index (ESI) triage levels and Simple Triage and Rapid Treatment (START) triage colors for urgent care and hospitalization. DESIGN: Cross sectional. SETTING: Inner city emergency department (ED). PARTICIPANTS: Patients years transported by Emergency Medical Services (EMS) participating in the state triage tag exercise, October 9-15, 2011. INTERVENTIONS: EMS assigned each patient a START triage tag. ED staff recorded tag number and color. Demographics, vital signs, 22 emergent interventions, and disposition were obtained via chart review. Institutional review board approval was obtained. MAIN OUTCOME MEASURES: Presence of more than two abnormal

vital sign on arrival and need for more than one emergent intervention in ED were considered indicators of acuity and severity. START triage colors were recategorized as urgent (Red, Yellow) and less acute (Green, White), and ESI was recategorized as urgent (1, 2, 3) and less acute (4, 5). RESULTS: Both ED and EMS staff were blinded to the study, and 95% confidence intervals were presented for statistical significance. Of 233 participants, START triage colors were Black=0, Red=12 percent, Yellow=26 percent, Green=53 percent, and White=9 percent. ESI triage levels were level 1=1 percent, level 2=34 percent, level 3=51 percent, level 4=14 percent, and level 5=1 percent. ESI (1, 2, 3) identified 88 percent (75-95 percent) of 49 patients with abnormal vital signs; START (Red, Yellow) only identified 51 percent (35-64 percent). Twenty-one patients needed emergent intervention. ESI (1, 2, 3) identified 95 percent (76-99 percent) of these patients; START (Red, Yellow) identified 33 percent (17-55 percent). ESI (1, 2, 3) identified 98 percent of the 96(92-100 percent) admitted patients; only 48 percent (38-58 percent) were tagged START (Red, Yellow). CONCLUSION: ESI better identified patients with abnormal vital signs, those who needed emergent interventions, and those admitted than START.

Hsia, R. Y., Friedman, A. B. et Niedzwiecki, M. (2016). "Urgent Care Needs Among Nonurgent Visits to the Emergency Department." JAMA Intern Med 176(6) : 852-854.

Hugli, O. W., Potin, M., Schreyer, N., et al. (2006). "[Emergency department overcrowding: A legitimate reason to refuse access to urgent care for non-urgent patients?]." Rev Med Suisse 2(75) : 1836-1839.

Non-urgent cases represent 30-40% of all ED consults; they contribute to overcrowding of emergency departments (ED), which could be reduced if they were denied emergency care. However, no triage instrument has demonstrated a high enough degree of accuracy to safely rule out serious medical conditions: patients suffering from life-threatening emergencies have been inappropriately denied care. Insurance companies have instituted financial penalties to discourage the use of ED as a source of non-urgent care, but this practice mainly restricts access for the underprivileged. More recent data suggest that in fact most patients consult for appropriate urgent reasons, or have no alternate access to urgent care. The safe reduction of overcrowding requires a reform of the healthcare system based on patients' needs rather than access barriers.

Hurst, K. (2008). "How well are England's urgent care services performing?" Nurs Stand 23(12) : 14-15.

Ijzermans, C. J., Mentink, S., Klaphake, L. M. M., et al. (2002). "Contacts outside of office hours:complaints presented to the general practitioner and to the emergency department." Ned Tijdschr Geneeskd 146(30) : 1413-1417.

Irwin, A. J. (2019). "Improving patient satisfaction at a rural urgent care center." Nursing 49(3) : 18-20.

Irwin, A. J. (2020). "Improving patient satisfaction at a rural urgent care center." Nurs Manage 51(2) : 13-15.

Isaacman, D. J., Kaminer, K., Veligeti, H., et al. (2001). "Comparative practice patterns of emergency medicine physicians and pediatric emergency medicine physicians managing fever in young children." Pediatrics 108(2) : 354-358.

Jimenez-Martin, S., Nicodemo, C. et Redding, S. (2017). The effect of changing the number of elective hospital admissions on the levels of emergency provision. Economics Working Papers; 1582. Barcelone Universitat Pompeu Fabra
https://econ-papers.upf.edu/papers/1582.pdf

> In England as elsewhere, policy makers are trying to reduce the pressure on costs caused by rising hospital admissions by encouraging GPs to refer less patients to hospital specialists. This could have an impact on elective treatment levels, particularly procedures for conditions which are not life-threatening and can be delayed or perhaps withheld entirely. This study attempts to identify the potential consequences on levels of emergency treatment if elective care is managed downwards. Using administrative data from Hospital Episode Statistics (HES) in England we estimate dynamic fixed effects panel data models for emergency admissions at Primary Care Trust and Hospital Trust levels for the years 2004–13, controlling for a group of area-specific characteristics and other secondary care variables. We find that increasing levels of elective care tends to increase the future requirement for emergency treatment. While there is no guarantee that the positive correlation between emergency and elective activity will persist if policy is effective in reducing levels of elective treatment, it does suggest that the cost-saving benefits to the NHS from reducing elective treatment may not be as great in aggregate as anticipated.

Johnston, C. L., Coulthard, M. G., Schluter, P. J., et al. (2001). "Medical emergencies in general practice in south-east Queensland: prevalence and practice preparedness." Medical Journal of Australia 175(2) : 99-103.

Jollivet, J. F. (2019). "Attente, urgences, gradation des soins : les faiblesses du système de santé suédois." Gestions Hospitalières (585) : 207-214.

> Si le système de santé suédois passe pour être globalement très bon, il constitue néanmoins un sujet majeur de préoccupation des Suédois, comme les élections générales de septembre 2018 l'ont rappelé. En particulier, l'accès aux soins de santé est perçu comme perfectible, tant pour les soins de premier recours en centre de santé que pour les urgences. Pour les adultes, le délai médian de contact médical aux urgences est deux fois plus élevé en Suède qu'en France, à environ 60 minutes. La durée médiane totale de passage aux urgences est d'environ 3 heures 30, ce qui est également plus important qu'en France d'environ 1 heure. Cette situation invite à des politiques publiques que les régions, en charge de la délivrance des soins de santé, articulent tant sur le volet préhospitalier que sur l'organisation des services d'urgences eux-mêmes.

Keoch, B. (2013). Transforming urgent and emergency care services in England : Urgent and emergency care review end of phase 1 report. Londres NHS
http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

> Le gouvernement britannique devrait dévoiler en mars une série de mesures visant à réduire d'environ 600 millions d'€ chaque année les dépenses publiques de santé dès 2015. La réforme repose essentiellement sur la suppression de certaines prestations gratuites accordées aux étrangers non membres de l'Espace économique européen qui ne cotisent pas au NHS (National Health Service). Afin d'accéder aux services d'urgences des hôpitaux britanniques, ces derniers devront donc s'acquitter d'un montant forfaitaire, qui pourrait atteindre une centaine d'€. L'objectif est d'abord de désengorger des services au bord de

l'implosion. Ce rapport fait un bilan des services d'urgence anglais (A&E - Accident & Emergency).

Khangura, J. K., Flodgren, G., Perera, R., et al. (2012). "Primary care professionals providing non-urgent care in hospital emergency departments." Cochrane Database Syst Rev 11 : Cd002097.

BACKGROUND: In many countries emergency departments (EDs) are facing an increase in demand for services, long-waits and severe crowding. One response to mitigate overcrowding has been to provide primary care services alongside or within hospital EDs for patients with non-urgent problems. It is not known, however, how this impacts the quality of patient care, the utilisation of hospital resources, or if it is cost-effective. OBJECTIVES: To assess the effects of locating primary care professionals in the hospital ED to provide care for patients with non-urgent health problems, compared with care provided by regular Emergency Physicians (EPs), SEARCH METHODS: We searched the Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialized register; Cochrane Central Register of Controlled Trials (The Cochrane library, 2011, Issue 4), MEDLINE (1950 to March 21 2012); EMBASE (1980 to April 28 2011); CINAHL (1980 to April 28 2011); PsychINFO (1967 to April 28 2011); Sociological Abstracts (1952 to April 28 2011); ASSIA (1987 to April 28 2011); SSSCI (1945 to April 28 2011); HMIC (1979 to April 28 2011), sources of unpublished literature, reference lists of included papers and relevant systematic reviews. We contacted experts in the field for any published or unpublished studies, and hand searched ED conference abstracts from the last three years. SELECTION CRITERIA: Randomised controlled trials, non-randomised studies, controlled before and after studies and interrupted time series studies that evaluated the effectiveness of introducing primary care professionals to hospital EDs to attend to non-urgent patients, as compared to the care provided by regular EPs. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data and assessed the risk of bias for each included study. We contacted authors of included studies to obtain additional data. Dichotomous outcomes are presented as risk ratios (RR) with 95% confidence intervals (CIs) and continuous outcomes are presented as mean differences (MD) with 95% CIs. Pooling was not possible due to heterogeneity. MAIN RESULTS: Three non randomised controlled studies involving a total of 11 203 patients, 16 General Practioners (GPs), and 52 EPs, were included. These studies evaluated the effects of introducing GPs to provide care to patients with non-urgent problems in the ED, as compared to EPs for outcomes such as resource use. The quality of evidence for all outcomes in this review was low, primarily due to the non-randomised design of included studies.The outcomes investigated were similar across studies; however there was high heterogeneity (I(2)>86%). Differences across studies included the triage system used, the level of expertise and experience of the medical practitioners and type of hospital (urban teaching, suburban community hospital).Two of the included studies report that GPs used significantly fewer healthcare resources than EPs, with fewer blood tests (RR 0.22; 95%CI: 0.14 to 0.33; N=4641; RR 0.35; 95%CI 0.29 to 0.42; N=4684), x-rays (RR 0.47; 95% CI 0.41 to 0.54; N=4641; RR 0.77 95% CI 0.72 to 0.83; N=4684), admissions to hospital (RR 0.33; 95% CI 0.19 to 0.58; N=4641; RR 0.45; 95% CI 0.36 to 0.56; N=4684) and referrals to specialists (RR 0.50; 95% CI 0.39 to 0.63; N=4641; RR 0.66; 95% CI 0.60 to 0.73; N=4684). One of the two studies reported no statistically significant difference in the number of prescriptions made by GPs compared with EPs, (RR 0.95 95% CI 0.88 to 1.03; N=4641), while the other showed that GPs prescribed significantly more medications than EPs (RR 1.45 95% CI 1.35 to 1.56; N=4684). The results from these two studies showed marginal cost savings from introducing GPs in hospital EDs.The third study (N=1878) failed to identify a significant difference in the number of blood tests ordered (RR 0.96; 95% CI 0.76 to 1.2), x-rays (RR 1.07; 95%CI 0.99 to 1.15), or

admissions to hospital (RR 1.11; 95% CI 0.70 to 1.76), but reported a significantly greater number of referrals to specialists (RR 1.21; 95% CI 1.09 to 1.33) and prescriptions (RR 1.12; 95% CI 1.01 to 1.23) made by GPs as compared with EPs.No data were reported on patient wait-times, length of hospital stay, or patient outcomes, including adverse effects or mortality. AUTHORS' CONCLUSIONS: Overall, the evidence from the three included studies is weak, as results are disparate and neither safety nor patient outcomes have been examined. There is insufficient evidence upon which to draw conclusions for practice or policy regarding the effectiveness and safety of care provided to non-urgent patients by GPs versus EPs in the ED to mitigate problems of overcrowding, wait-times and patient flow.

Kirkner, R. M. (2014). "Urgent care finds its place in the age of ACOs." Manag Care 23(11) : 20-21, 24-25.

Kmietowicz, Z. (2015). "Emergency care specialists renew call for out-of-hours services to be located in hospitals." BMJ 351.
https://www.bmj.com/content/351/bmj.h5932

Zosia Kmietowicz1The BMJOut-of-hours urgent and emergency primary care services should be located in hospital emergency departments with immediate effect, specialists have said.In a joint position statement the Royal College of Emergency Medicine and Urgent Health UK, the federation of social enterprise providers of unscheduled primary care, said that the move would secure safer, simpler, and more effective access for patients with urgent healthcare needs outside normal GP clinic hours.Chris Moulton, vice president of the Royal College of Emergency Medicine, said, “Recent research by the Royal College of Emergency Medicine has confirmed that around …

Knowles, E. (2019). "The impact of closing emergency departments on mortality in emergencies: an observational study." JMIR Public Health Surveill 36(11) : 645-651.

BACKGROUND: In England the demand for emergency care is increasing, while there is also a staffing shortage. This has implications for quality of care and patient safety. One solution may be to concentrate resources on fewer sites by closing or downgrading emergency departments (EDs). Our aim was to quantify the impact of such reorganisation on population mortality. METHODS: We undertook a controlled interrupted time series analysis to detect the impact of closing or downgrading five EDs, which occurred due to concerns regarding sustainability. We obtained mortality data from 2007 to 2014 using national databases. To establish ED resident catchment populations, estimated journey times by road were supplied by the Department for Transport. Other major changes in the emergency and urgent care system were determined by analysis of annual NHS Trust reports in each geographical area studied. Our main outcome measures were mortality and case fatality for a set of 16 serious emergency conditions. RESULTS: For residents in the areas affected by closure, journey time to the nearest ED increased (median change 9 min, range 0-25 min). We found no statistically reliable evidence of a change in overall mortality following reorganisation of ED care in any of the five areas or overall (+2.5% more deaths per month on average; 95% CI -5.2% to +10.2%; p=0.52). There was some evidence to suggest that, on average across the five areas, there was a small increase in case fatality, an indicator of the 'risk of death' (+2.3%, 95% CI +0.9% to+3.6%; p<0.001), but this may have arisen due to changes in hospital admissions. CONCLUSIONS: We found no evidence that reorganisation of emergency care was associated with a change in population mortality in the five areas studied. Further research should

establish the economic consequences and impact on patient experience and neighbouring hospitals.

Knowles, E., Shephard, N., Stone, T., et al. (2018). Health Services and Delivery Research. Closing five Emergency Departments in England between 2009 and 2011: the closED controlled interrupted time-series analysis. Southampton (UK), NIHR Journals Library

BACKGROUND: In recent years, a number of emergency departments (EDs) have closed or have been replaced by another facility such as an urgent care centre. With further reorganisation of EDs expected, this study aimed to provide research evidence to inform the public, the NHS and policy-makers when considering local closures. OBJECTIVE: To understand the impact of ED closures/downgrades on populations and emergency care providers. DESIGN: A controlled interrupted time series of monthly data to assess changes in the patterns of mortality in local populations and changes in local emergency care service activity and performance, following the closure of type 1 EDs. SETTING: The populations of interest were in the resident catchment areas of five EDs that closed between 2009 and 2011 (in Newark, Hemel Hempstead, Bishop Auckland, Hartlepool and Rochdale) and of five control areas. MAIN OUTCOME MEASURES: The primary outcome measures were ambulance service incident volumes and times, the number of emergency and urgent care attendances at EDs, the number of emergency hospital admissions, mortality, and case fatality ratios. DATA SOURCES: Data were sourced from the Office for National Statistics, Hospital Episode Statistics (HES) accident and emergency, HES admitted patient care and ambulance service computer-aided dispatch records. RESULTS: There was significant heterogeneity among sites in the results for most of the outcome measures, but the overall findings were as follows: there is evidence of an increase, on average, in the total number of incidents attended by an ambulance following 999 calls, and those categorised as potentially serious emergency incidents; there is no statistically reliable evidence of changes in the number of attendances at emergency or urgent care services or emergency hospital admissions; there is no statistically reliable evidence of any change in the number of deaths from a set of emergency conditions following the ED closure in any site, although, on average, there was a small increase in an indicator of the 'risk of death' in the closure areas compared with the control areas. LIMITATIONS: Unavailable or unreliable data hindered some of the analysis regarding ED and ambulance service performance. CONCLUSIONS: Overall, across the five areas studied, there was no statistically reliable evidence that the reorganisation of emergency care was associated with an increase in population mortality. This suggests that any negative effects caused by increased journey time to the ED can be offset by other factors; for example, if other new services are introduced and care becomes more effective than it used to be, or if the care received at the now-nearest hospital is more effective than that provided at the hospital where the ED closed. However, there may be implications of reorganisation for NHS emergency care providers, with ambulance services appearing to experience a greater burden. FUTURE WORK: Understanding why effects vary between sites is necessary. It is also necessary to understand the impact on patient experience. Economic evaluation to understand the cost implications of such reorganisation is also desirable. FUNDING: The National Institute for Health Research Health Services and Delivery Research programme.

Knowles, E., O'Cathain, A., Turner, J., et al. (2014). "Awareness and use of a new urgent care telephone service, NHS 111 : cross-sectional population survey." J Health Serv Res Policy 19(4) : 224-230.

OBJECTIVES: Telephone-accessed health care plays a significant part in the delivery of urgent care internationally. NHS 111 is a telephone service set up to improve and simplify access to non-emergency National Health Service health care in England. The first aim of this research was to describe population awareness and use of this new service, overall and within different sub-groups. In doing so, the second aim was to identify any inequity in awareness or use of telephone-accessed health care. METHODS: We undertook a telephone survey to assess awareness and use of NHS 111 in four sites. Random digit dialing was undertaken to identify 2000 respondents in each site. The survey was undertaken in 2011, approximately 9-10 months after the launch of NHS 111 in each site. Eight thousand and ten members of the general population completed a questionnaire. RESULTS: Fifty-nine percent of respondents had heard of NHS 111 and 9% reported ever using NHS 111. Respondents were less likely to have used NHS 111 if they were older (p </= 0.001), male (p </= 0.001), and did not have a disability/limiting long-term illness (p </= 0.001) or own their home (p = 0.039). CONCLUSIONS: The use of the telephone as an important means of access to urgent care may be problematic if some groups in the population are less likely to use it. Policy makers and service providers may need to consider other ways of offering access to care or deliver targeted publicity campaigns to encourage the use of telephone-accessed health care amongst specific groups within a population.

Knowles, E., O'Cathain, A., Turner, J., et al. (2016). "Effect of a national urgent care telephone triage service on population perceptions of urgent care provision: controlled before and after study." BMJ Open 6(10) : e011846.

OBJECTIVE: To measure the effect of an urgent care telephone service NHS 111 on population perceptions of urgent care. DESIGN: Controlled before and after population survey, using quota sampling to identify 2000 respondents reflective of the age/sex profile of the general population. SETTING: England. 4 areas where NHS 111 was introduced, and 3 control areas where NHS 111 had yet to be introduced. PARTICIPANTS: 28 071 members of the general population, including 2237 recent users of urgent care. INTERVENTION: NHS 111 offers advice to members of the general population seeking urgent care, recommending the best service to use or self-management. Policymakers introduced NHS 111 to improve access to urgent care. OUTCOMES MEASURES: The primary outcome was change in satisfaction with recent urgent care use 9 months after the launch of NHS 111. Secondary outcomes were change in satisfaction with urgent care generally and with the national health service. RESULTS: The overall response rate was 28% (28 071/100 408). 8% (2237/28 071) had used urgent care in the previous 3 months. Of the 652 recent users of urgent care in the NHS 111 intervention areas, 9% (60/652) reported calling NHS 111 in the 'after' period. There was no evidence that the introduction of NHS 111 was associated with a changed perception of recent urgent care. For example, the percentage rating their experience as excellent remained at 43% (OR 0.97, 95% CI 0.69 to 1.37). Similarly, there was no change in population perceptions of urgent care generally (1.06, 95% CI 0.95 to 1.17) or the NHS (0.94, 95% CI 0.85 to 1.05) following the introduction of NHS 111. CONCLUSIONS: A new telephone triage service did not improve perceptions of urgent care or the health service. This could be explained by the small amount of NHS 111 activity in a large emergency and urgent care system.

Kralewski, J., Dowd, B., Knutson, D., et al. (2013). "Medical group practice characteristics influencing inappropriate emergency department and avoidable hospitalization rates." Journal of Ambulatory Care Management 36(4) : 286-291.

Kroll, D. S., Wrenn, K., Grimaldi, J. A., et al. (2019). "Longitudinal Urgent Care Psychiatry as a Unique Access Point for Underserved Patients." Psychiatr Serv 70(9) : 837-839.

> OBJECTIVE: The authors sought to determine whether a walk-in psychiatry model with longitudinal follow-up capability could improve access for patients who traditionally miss appointments. METHODS: An urgent care clinic that offers treatment exclusively on a walk-in basis was opened within an adult psychiatry practice to accommodate patients who missed prior scheduled appointments. Electronic health records for patients who received an initial psychiatry evaluation at the practice during a 6-month period (N=355) were reviewed retrospectively to track the clinic's productivity and patient demographic characteristics. RESULTS: Eighty patients (23%) accessed their initial psychiatry encounters through the walk-in clinic. Medicaid recipients (odds ratio [OR]=1.89, 95% confidence interval [CI]=1.10-3.24) and individuals without a college degree (OR=1.86, 95% CI=1.04-3.32) were more likely than patients with other insurance carriers and those with a college degree, respectively, to access care through a walk-in encounter versus a scheduled appointment. CONCLUSIONS: Longitudinal walk-in psychiatry services can feasibly be offered through the longitudinal urgent care psychiatry model. This model may serve as a unique access point for patients from historically underserved groups.

Laurant, M., Van Der Biezen, M. et al. (2018). "Nurses as substitutes for doctors in primary care." Cochrane Database of Systematic Review(7): 82.

> The aim of this review was to investigate the impact of nurses working as substitutes for primary care doctors. It searched for studies that compared nurses to doctors for delivery of primary care services. We looked at whether this made any difference in patients' health, satisfaction, and use of services. We also looked at whether this made any difference in how services were delivered and in how much they cost.

Le, S. T. et Hsia, R. Y. (2016). "Community characteristics associated with where urgent care centers are located: a cross-sectional analysis." BMJ Open 6(4) : e010663.

> OBJECTIVES: To determine the community characteristics associated with non-hospital-based urgent care centres wherever they are located. DESIGN: National cross-sectional study evaluating the association between non-hospital-based urgent care centers, and their demographic characteristics in a community, using descriptive statistics and multivariate logistic regressions. SETTING: Communities in the USA with non-hospital-based urgent care centers, as identified using a 2014 national database from the Urgent Care Association of America. PARTICIPANTS: 31,022 communities encompassing 6898 urgent care centers across the USA. PRIMARY AND SECONDARY OUTCOME MEASURES: Presence of a non-hospital-based urgent care center within a community. RESULTS: Communities with non-hospital-based urgent care centers are urban (75.7% with vs 22.2% without; p<0.001 across rural urban commuting area levels), and are located in areas with higher income levels (38.6% in highest quartile with vs 22.3% without; p<0.001 across quartiles) and higher levels of private insurance (29.6% in highest quartile with vs 23.9% without; p<0.001 across quartiles). CONCLUSIONS: While the growth of the urgent care industry may have other promising implications, policymakers should recognise that it may exacerbate disparities in access to acute care faced by poorer, uninsured patients, and may also have financial implications for providers that are providing overlapping services, such as emergency departments and primary care practices.

Leikin, J. B. (2017). "Urgent care medicine and the role of the Advanced Practice Providers within this specialty." Dis Mon 63(5) : 104.

Leikin, J. B. (2017). "Urgent care medicine and the role of the APP within this specialty." Dis Mon.

Lima Cde, A., Santos, B. T., Andrade, D. L., et al. (2015). "Quality of emergency rooms and urgent care services: user satisfaction." Einstein (Sao Paulo) 13(4) : 587-593.

OBJECTIVE: To evaluate the quality of emergency rooms and urgent care services according to the satisfaction of their users. METHODS: A cross-sectional descriptive study with a quantitative approach. The sample comprised 136 users and was drawn at random. Data collection took place between October and November 2012 u sing a structured questionnaire. RESULTS: Participants were mostly male (64.7%) aged less than 30 years (55.8%), and the predominant level of education was high school (54.4%). Among the items evaluated, those that were statistically associated with levels of satisfaction with care were waiting time, confidence in the service, model of care, and the reason for seeking care related to acute complaints, cleanliness, and comfortable environment. CONCLUSION: Accessibility, hospitality, and infrastructure were considered more relevant factors for patient satisfaction than the cure itself.

Llovera, I., Loscalzo, K., Gao, J., et al. (2019). "Increased access to urgent care centers decreases low acuity diagnoses in a nearby hospital emergency department." Am J Emerg Med 37(3) : 486-488.

OBJECTIVE: We studied the impact four new urgent care centers (UCCs) had on a hospital emergency department (ED) in terms of overall census and proportion of low acuity diagnoses from 2009 to 2016. We hypothesized that low acuity medical problems frequently seen in UCCs would decrease in the ED population. Since Medicaid was not accepted at these UCCs, we also studied the Medicaid vs non-Medicaid discharged populations to see if there were some differences related to access to urgent care. METHODS: We conducted a retrospective review of computerized billing data. We included all patients from 2009 to 2016 who were seen in the ED. We used the Cochran-Armitage Trend Test to examine trends over time. RESULTS: As hypothesized, the proportion of ED patients with a diagnosis of pharyngitis decreased significantly over this time period from 1% to 0.6% ($p<0.0001$). The rate of bronchitis in the total ED population also decreased significantly (0.5% to 0.13%, $p<0.0001$).When we looked at the discharged patients with and without Medicaid, we found that significantly more Medicaid than non-Medicaid patients presented with pharyngitis to the ED with an increasing trend from 2009 to 2016: OR=2.33, $p<0.0001$. The overall census of the ED rose over the period 2009 to 2016 (80,478 to 85,278/year). Overall admission rates decreased significantly: 36.9% to 34.5% ($p<0.0001$). CONCLUSION: With the introduction of four new urgent care centers (UCCs) within 5miles of the hospital, the ED diagnoses of pharyngitis and bronchitis, two of the most common diagnoses seen in UCCs, decreased significantly. Significantly more Medicaid discharged patients presented to the ED with pharyngitis than in the non-Medicaid discharged group, likely because Medicaid patients had no access to UCCs.

Loxterkamp, D. (2015). "An inconvenient truth: urgent care is not primary care." BMJ 350 : h1657.

Manley, M. (2013). "The pros and cons of expanding into urgent care." Med Econ 90(22) : 58, 60.

McHugh, S., Droog, E., Foley, C., et al. (2019). "Understanding the impetus for major systems change: A multiple case study of decisions and non-decisions to reconfigure emergency and urgent care services." Health Policy 123(8) : 728-736.

> OBJECTIVE: The optimal organisation of emergency and urgent care services (EUCS) is a perennial problem internationally. Similar to other countries, the Health Service Executive in Ireland pursued EUCS reconfiguration in response to quality and safety concerns, unsustainable costs and workforce issues. However, the implementation of reconfiguration has been inconsistent at a regional level. Our aim was to identify the factors that led to this inconsistency. METHODS: Using a multiple case study design, six case study regions represented full, partial and little/no reconfiguration at emergency departments (EDs). Data from documents and key stakeholder interviews were analysed using a framework approach with cross-case analysis. RESULTS: The impetus to reconfigure ED services was triggered by patient safety events, and to a lesser extent by having a region-specific plan and an obvious starting point for changes. However, the complexity of the next steps and political influence impeded reconfiguration in several regions. Implementation was more strategic in regions that reconfigured later, facilitated by clinical leadership and "lead-in time" to plan and sell changes. CONCLUSION: While the global shift towards centralisation of EUCS is driven by universal challenges, decisions about when, where and how much to implement are influenced by local drivers including context, people and politics. This can contribute to a public perception of inequity and distrust in proposals for major systems change.

Mehta, N., Kpelitse, K. A., Devlin, R. A., et al. (2017). Primary Care Access and Emergency Department Utilization: Theory and Evidence from Canada. Working Paper No 170005

> We develop a theoretical model to study how after-hours incentives affect emergency department (ED) utilization via changing physician behavior. The model reveals that reductions in ED utilization can only come from patients with conditions severe enough to warrant visiting the ED, yet mild enough to be treatable by their primary care physician. While these incentives induce physicians to work more after hours, they also reduce regular-hours services. Thus, incentivizing physicians to provide after-hours services ambiguously affects ED utilization. Model predictions are tested using administrative data from the province of Ontario, Canada. The data cover visits to physicians offices and ED visits from 2004 to 2013, a period with exogenous changes in after-hours incentives. Our findings are consistent with model predictions. We also find that after-hours incentives reduce ED visits, suggesting that our proposed framework may be useful for understanding and even designing after-hours incentives.

Memmel, J. et Spalsbury, M. (2017). "Urgent care medicine and the role of the APP within this specialty." Dis Mon 63(5) : 105-114.

> The field of urgent care medicine offers an additional medical pathway for patients who have immediate, but non-life-threatening, medical concerns. Urgent care medicine offers a more varied set of resources and services than a physician office setting, with more flexible hours. This gives patients an opportunity to not have to go to the emergency department for non-emergent care. As a newer specialty within the medical field, certain roles of healthcare providers other than physicians are becoming established, including the advanced practice provider (APP). An APP is a nurse practitioner or a physician assistant, who is licensed to treat under the supervision of a physician. Nurse practitioners' (NP) and physician assistants' (PA) role in urgent care is often seen as an effective, lower cost option to manage common acute

minor illnesses seen in the community. Benefits to utilizing APPs in urgent care include decreasing costs to both the patient and health system, enhancing the physician's ability to see more patients, and decreasing wait times, all while continuing to maintain high standards of care. The goal of the authors within this publication is to discuss urgent care as a specialty and further explore the role of advanced practice providers within this setting.

Momanyi, K. (2017). Telecare and Unplanned Hospitalisation in Scotland: Evidence from Linked Survey and Administrative Data. Aberdeen University of Aberdeen**:** Pas encore accessible en ligne. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3061435

In the face of increasing health care costs, policy makers in Scotland are interested in coming up with innovative ways of reducing unplanned hospital admissions. This paper investigates whether the use of telecare devices could be one such way. We link the Scottish Homecare Census data to three other information sources–including the Scottish Morbidity Records–and estimate the treatment effect using time series analysis. Unlike the previous studies that find telecare users to have a lower likelihood of unplanned hospitalisation than non-users, our results show that the treatment effect varies for different telecare devices.

Montalbano, A., Montgomery, E., Johnson, J., et al. (2019). "A Response to "Pediatric Referrals to an Emergency Department From Urgent Care Centers". Int J Health Plann Manage.

Montalbano, A., Rodean, J., Canares, T., et al. (2017). "Urgent Care Utilization in the Pediatric Medicaid Population." J Pediatr 191 : 238-243.e231.

OBJECTIVE: To assess healthcare utilization patterns associated with high (>/=3 visits/year) urgent care utilization. STUDY DESIGN: Retrospective analysis of 2 723 792 children who were less than 19 years of age in the 2013 Marketscan Medicaid database. Healthcare utilization categorized as inpatient, emergency department, urgent care, well-child primary care provider (PCP), acute PCP, and specialist visits was documented for 4 groups. We hypothesized that children with high urgent care utilization would have decreased utilization at other sites of care. Multivariable logistic models compared the odds of high urgent care utilization. RESULTS: Of children in the study population, 92.0% had no urgent care visits; 4.7% had 1; 1.5% had 2; and 1.0% had >/=3. Patient attributes of high urgent care utilization were: ages 1-2 years (aOR = 2.32, 95% CI: 2.18-2.36, reference group: 13-18 years), presence of a complex chronic condition (CCC) (aOR = 1.98, 95% CI: 1.88-2.07, reference group: no CCC) and no CCC but >/=3 chronic conditions (aOR = 2.85, 95% CI: 2.73-2.97, reference group: no CCC, no chronic conditions). High urgent care utilization was associated with >/=5 PCP visits for acute care (aOR = 1.16, 95% CI: 1.11-1.20, reference group: 0 visits), and >/=3 emergency department visits (aOR = 2.15, 95% CI: 2.10-2.23, reference group: 0 visits). CONCLUSIONS: Increased urgent care utilization was associated with an increase in overall healthcare utilization. Even though those with higher urgent care utilization had more visits for acute care, patients continued to see their PCP for both well-child and acute care visits.

Moore, A. (2007). "Out-of-hours-care. The urgent care muddle may mean more nights to forget." Health Serv J 117(6048) : 14-15.

Morreel, S., Philips, H. et Verhoeven, V. (2019). "Self-triage at an urgent care collaboration with and without information campaign." J Emerg Manag 17(6) : 511-516.

BACKGROUND: Patients in Belgium needing out-of-hours care have two options: the emergency department (ED) or the general practitioner on call. The latter is often organized in a General Practice Cooperative (GPC). At the ED, there is an overload of patients who could be helped more efficiently by the GPC. RESEARCH QUESTION: What is the proportion of patients switching from the ED to the GPC (called voluntary switchers) with and without an information campaign? What are the characteristics of these patients? METHODS: Single-center prospective intervention trial during the opening hours of the GPC (only weekends: Friday 7.00 pm to Monday 7.00 am). The first 10 weekends there was no intervention. The next 24 weekends, patients in the ED were informed about the out-of-hours care in Belgium. The information contained several topics: characteristics of both services, where to go using examples, practicalities, and costs. This information was distributed through leaflets and broadcasted on a screen in five languages. RESULTS: During the study period, 7,453 patients entered the ED of which 330 are voluntary switchers. The proportion of voluntary switchers was 1.7 percent before and 5.4 percent after the intervention ($p < 0.01$). This effect remained stable for 10 more months after the study. The average number of patients presenting at the ED per hour was 3.1, whereas on hours with voluntary switchers was 5.1 ($p < 0.01$). The age distribution and epidemiological profile of the voluntary switchers resembles the one of primary care patients. The general practicioners (GPs) referred 6 percent of the voluntary switchers back to the ED. CONCLUSION: Co-location of the GPC and the ED and informing patients is a meaningful step toward a more profound collaboration.

Morton, S., Ignatowicz, A., Gnani, S., et al. (2016). "Describing team development within a novel GP-led urgent care centre model: a qualitative study." 6(6) : e010224.

OBJECTIVE: Urgent care centres (UCCs) co-located within an emergency department were developed to reduce the numbers of inappropriate emergency department admissions. Since then various UCC models have developed, including a novel general practitioner (GP)-led UCC that incorporates both GPs and emergency nurse practitioners (ENPs). Traditionally these two groups do not work alongside each other within an emergency setting. Although good teamwork is crucial to better patient outcomes, there is little within the literature about the development of a team consisting of different healthcare professionals in a novel healthcare setting. Our aim was therefore to describe staff members' perspectives of team development within the GP-led UCC model. DESIGN: Open-ended semistructured interviews, analysed using thematic content analysis. SETTING: GP-led urgent care centres in two academic teaching hospitals in London. PARTICIPANTS: 15 UCC staff members including six GPs, four ENPs, two receptionists and three managers. RESULTS: Overall participants were positive about the interprofessional team that had developed and recognised that this process had taken time. Hierarchy within the UCC setting has diminished with time, although some residual hierarchical beliefs do appear to remain. Staff appreciated interdisciplinary collaboration was likely to improve patient care. Eight key facilitating factors for the team were identified: appointment of leaders, perception of fair workload, education on roles/skill sets and development of these, shared professional understanding, interdisciplinary working, ED collaboration, clinical guidelines and social interactions. CONCLUSIONS: A strong interprofessional team has evolved within the GP-led UCCs over time, breaking down traditional professional divides. Future implementation of UCC models should pro-actively incorporate the eight facilitating factors identified from the outset, to enable effective teams to develop more quickly.

Mroz, T. M., Andrilla, C. H. A., Garberson, L. A., et al. (2018). "Service provision and quality outcomes in home health for rural Medicare beneficiaries at high risk for unplanned care." Home Health Care Serv Q 37(3) : 141-157.

> Multiple barriers exist to providing home health care in rural areas. This study examined relationships between service provision and quality outcomes among rural, fee-for-service Medicare beneficiaries who received home health care between 2011 and 2013 for conditions associated with high-risk for unplanned care. More skilled nursing visits, visits by more types of providers, more timely care, and shorter lengths of stay were associated with significantly higher odds of hospital readmission and emergency department use and significantly lower odds of community discharge. Results may indicate unmeasured clinical severity and care needs among this population. Additional research regarding the accuracy of current severity measures and adequacy of case-mix adjustment for quality metrics is warranted, especially given the continued focus on value-based payment policies.

Mudd, S. S., Alvarado, S. M., Otaru, S., et al. (2020). "Urgent Care Utilization in a Pediatric Population with Private Health Insurance." J Pediatr Health Care.

> INTRODUCTION: Pediatric urgent care (UC) utilization patterns have been studied in Medicaid enrollees, but not in those with private insurance. METHODS: Utilization patterns of UC at a suburban pediatric primary care practice with patients with private health insurance were reviewed. Descriptive data were obtained. RESULTS: Three hundred twenty-five charts were reviewed. Most UC visits were for children under 6 years of age (59.7%), a diagnosis of fever (12.2%), and with low severity illness (57.8%). Seventy percent occurred during weekdays and during times when the primary care practice was open. Most children (67.4%) had a diagnostic test performed at UC and 42.2% received a prescription for antibiotics. DISCUSSION: Primary care providers should target caregiver education on low acuity conditions and consider process improvements to accommodate urgent visits. While pediatric UC benchmarks are needed, data suggests that general UCs are at risk for overprescribing antibiotics compared to national ambulatory averages.

Myers, J. B., Cox, J., Teague, S., et al. (2016). "Transitions of Care Model Inclusive of Unplanned Care Improves the Patient Experience." J Patient Exp 3(1) : 20-23.

> A major emphasis in health care is creating an experience whereby patients receive the right care at the right time from the right provider in the right setting at the right cost. Over the past several decades, there has been considerable effort in the area of medical management, with prior authorization, gatekeeper utilization management regimens, and other techniques designed to guide patients and caregivers into desired treatment pathways. Alternatively, the concept of demand management may be employed to achieve these desired outcomes by giving patients meaningful, expanded choices beyond traditional acute-care settings. The implementation of a novel, patient-centered, unplanned care delivery model is described along with illustrative case studies.

Navarro, R. A., Lin, C. C., Foroohar, A., et al. (2018). "Unplanned emergency department or urgent care visits after outpatient rotator cuff repair: potential for avoidance." J Shoulder Elbow Surg 27(6) : 993-997.

> BACKGROUND: With the cost of health care rising, the potential to avoid costs from an unplanned return to the emergency department (ED) or urgent care center (UC) after

elective outpatient rotator cuff repair (RCR) has been discussed but not extensively assessed. METHODS: Outpatient RCR procedures were queried in a closed health care system, and all unplanned ED and UC visits within 7 days of procedures were collected and compared with other typical outpatient orthopedic procedures (knee arthroscopy, carpal tunnel release, and anterior cruciate ligament reconstruction). Avoidable diagnoses (ADs) for the unplanned visits were defined in advance as visits for (1) constipation, (2) nausea or vomiting, (3) pain, and (4) urinary retention. Final tallies of all visits versus visits with ADs were compared. RESULTS: From June 2015 to May 2016, 1306 outpatient RCRs were performed (729 male and 577 female patients; average age, 60 years). Of the patients, 90 returned for ED or UC visits (6.9%), with 34 for ADs (2.6%). Pain was the most common AD. However, when RCR was compared with other case types, ED or UC visits for urinary retention were significantly more common (P = .007), whereas there was no significant difference with the other ADs. The 1306 RCRs led to a greater proportion of ED or UC visits than the combined 5825 other cases studied (P < .001). DISCUSSION AND CONCLUSIONS: Unplanned ED visits within 7 days of outpatient RCR are measurable and in many cases, such as ED or UC visits for pain, are avoidable. Visits for urinary retention are seen more commonly after RCR. Outpatient RCR led to more unplanned ED and UC visits than other common outpatient orthopedic surgical procedures.

NHS (2019). The NHS Long Term Plan. Londres NHS
https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

The NHS Long Term Plan sets out its priorities for healthcare over the next 10 years and shows how the NHS funding settlement will be used. This plan focuses on improving services outside hospitals and moving towards more joined-up, preventative and personalised care for patients, and the ambition to establish integrated care systems in every part of the country by 2021.The plan includes measures to: improve out-of-hospital care, supporting primary medical and community health services; ensure all children get the best start in life by continuing to improve maternity safety; support older people through more personalised care and stronger community and primary care services; and make digital health services a mainstream part of the NHS.

Nichols, J., England, R., Holliday, S., et al. (2019). "Clinical Care Pharmacists in Urgent Care in North East England: A Qualitative Study of Experiences after Implementation." Pharmacy (Basel) 7(3).

Our objective was to explore the implementation of a novel NHS England (NHSE)-funded pilot project aimed at deploying clinical pharmacists in an integrated urgent care (IUC) setting including the NHS 111 service. Eight integrated urgent care clinical pharmacists (IUCCPs) within the participating North East of England Trusts. Individuals participated in semi-structured 1-to-1 interviews by an experienced qualitative researcher, either face-to-face or via the telephone. Each recording was transcribed, and the five stages of framework analysis (familiarisation, identifying a thematic framework, indexing, charting, mapping and interpretation) took place to establish emerging themes. All interviews took place between November 2018-February 2019. Four higher-order themes were identified: 1. Personality Traits, 2. Integration, 3. Benefits, 4. Training. The IUCCP programme is an innovative NHSE initiative. It provides an opportunity to extend the role of clinical pharmacists into the hard-pressed clinical environment of urgent and emergency care. Our evaluation has highlighted the potential for this professional group to contribute clinically in this area. Better communications, standard operating procedures and induction will improve how individuals develop in these novel roles.

O'Cathain, A. et Connell, J. (2020). "'Clinically unnecessary' use of emergency and urgent care: A realist review of patients' decision making." 23(1) : 19-40.

> BACKGROUND: Demand is labelled 'clinically unnecessary' when patients do not need the levels of clinical care or urgency provided by the service they contact. OBJECTIVE: To identify programme theories which seek to explain why patients make use of emergency and urgent care that is subsequently judged as clinically unnecessary. DESIGN: Realist review. METHODS: Papers from four recent systematic reviews of demand for emergency and urgent care, and an updated search to January 2017. Programme theories developed using Context-Mechanism-Outcome chains identified from 32 qualitative studies and tested by exploring their relationship with existing health behaviour theories and 29 quantitative studies. RESULTS: Six mechanisms, based on ten interrelated programme theories, explained why patients made clinically unnecessary use of emergency and urgent care: (a) need for risk minimization, for example heightened anxiety due to previous experiences of traumatic events; (b) need for speed, for example caused by need to function normally to attend to responsibilities; (c) need for low treatment-seeking burden, caused by inability to cope due to complex or stressful lives; (d) compliance, because family or health services had advised such action; (e) consumer satisfaction, because emergency departments were perceived to offer the desired tests and expertise when contrasted with primary care; and (f) frustration, where patients had attempted and failed to obtain a general practitioner appointment in the desired timeframe. Multiple mechanisms could operate for an individual. CONCLUSIONS: Rather than only focusing on individuals' behaviour, interventions could include changes to health service configuration and accessibility, and societal changes to increase coping ability.

O'Cathain, A., Knowles, E. et Nicholl, J. (2011). "Measuring patients' experiences and views of the emergency and urgent care system: psychometric testing of the urgent care system questionnaire." BMJ Qual Saf 20(2) : 134-140.

> BACKGROUND: Patients seeking emergency and urgent care tend to experience a system, making choices about which service to use and making use of a number of services within a healthcare episode. The aim was to psychometrically test the Urgent Care System Questionnaire (UCSQ) for the routine measurement of the patient perspective of the emergency and urgent care system. METHODS: The UCSQ was developed based on qualitative research with recent users of the system. It consisted of a screening question to identify recent users and questions on the patient experience of, and satisfaction with, their most recent event. The acceptability, validity and reliability of the UCSQ were tested in a postal survey of 900 members of the general population and a telephone survey of a quota sample of 1000 members of the general population. RESULTS: The response rate to the postal survey was 51% (457/893). In the telephone survey, 11604 calls were made to obtain a quota sample of 1014 people. These surveys identified 250 system users in the previous 3 months. A principal-components analysis identified three satisfaction components with good internal consistency (Cronbach alpha between 0.7 and 0.93): 'progress through the system' (10 items), 'entry into the system' (three items) and 'patient convenience' (five items). These components varied as expected by age and overall rating of the system. CONCLUSION: Preliminary testing suggests that the UCSQ has reasonable acceptability, validity and reliability. Further testing is required, particularly its responsiveness to changes in emergency and urgent care systems.

O'Cathain, A., Knowles, E., Turner, J., et al. (2016). "Variation in avoidable emergency admissions: multiple case studies of emergency and urgent care systems." J Health Serv Res Policy 21(1) : 5-14.

OBJECTIVE: To identify factors affecting variation in avoidable emergency admissions that are not usually identified in statistical regression. METHODS: As part of an ethnographic residual analysis, we compared six emergency and urgent care systems in England, interviewing 82 commissioners and providers of key emergency and urgent care services. RESULTS: There was variation between the six cases in how interviewees described three parts of their emergency and urgent care systems. First, interviewees' descriptions revealed variation in the availability of services before patients decided to attend emergency departments. Poor availability of general practice out of hours services in some of the cases reportedly made attendance at emergency departments the easier option for patients. Second, there was variation in how interviewees described patients being dealt with during their emergency department visit in terms of availability of senior review by specialists and in coding practices when patients were at risk of breaching the NHS's 4-hour waiting time target. Third, there was variability in services described as facilitating discharge home from emergency departments. In some cases, emergency department staff described dealing with multiple agencies in multiple localities outside the hospital, making admission the easier option. In other cases, proactive multidisciplinary rapid assessment teams were described as available to avoid admissions. Perceptions of resources available out of hours and the extent of integration between different health services, and between health and social services, also differed by case. CONCLUSIONS: This comparative case study approach identified further factors that may affect avoidable emergency admissions. Initiatives to improve GP out of hours services, make coding more accurately reflect patient experience, increase senior review in emergency departments, offer proactive multidisciplinary admission avoidance teams, improve the availability of out of hours care in the wider emergency and urgent care system, and increase service integration may reduce avoidable admissions. Evaluation of such initiatives would be necessary before wide-scale adoption.

O'Cathain, A., Knowles, E., Turner, J., et al. (2014). Health Services and Delivery Research. Explaining variation in emergency admissions: a mixed-methods study of emergency and urgent care systems. Southampton (UK), NIHR Journals Library

BACKGROUND: Recent increases in emergency admission rates have caused concern. Some emergency admissions may be avoidable if services in the emergency and urgent care system are available and accessible. A set of 14 conditions, likely to be rich in avoidable emergency admissions, was identified by expert consensus. OBJECTIVE: We aimed to understand variation in avoidable emergency admissions between different emergency and urgent care systems in England. METHODS: The design was a sequential mixed-methods study in three phases. In phase 1 we calculated an age- and sex-adjusted avoidable admission rate for 2008-11. We located routine data on characteristics of emergency and urgent care systems and used linear regression to explain variation in avoidable admissions rates in 150 systems. In phase 2 we undertook in-depth case studies in six systems to identify further factors. A key part of these case studies was interviews with commissioners, service providers and patient representatives, totalling 82 interviews. In phase 3 we returned to the linear regression to test further factors identified in the case studies. RESULTS: The 14 conditions accounted for 3,273,395 admissions in 2008-11 (22% of all emergency admissions). The mean age- and sex-adjusted admission rate was 2258 per year per 100,000 population, with a 3.4-fold variation between systems (1268-4359). Characteristics of the population explained the majority of variation: deprivation explained 72% of variation, with urban/rural status explaining 3% more. Systems serving populations with high levels of deprivation and in urban areas had high rates of potentially avoidable admissions. Interviewees described the complexity of

deprivation, representing high levels of morbidity, low awareness of alternative services to emergency departments and high expressed need for immediate access to urgent care. Factors related to emergency departments (EDs), hospitals, emergency ambulance services and general practice explained a further 10% of variation in avoidable admissions. Systems with high, potentially avoidable, admission rates had high rates of acute beds (suggesting supply-induced demand), high rates of attendance at EDs (which have been associated with poor perceived access to general practice), high rates of conversion from ED attendances to admissions, and low rates of non-transport to emergency departments by emergency ambulances. The six case studies revealed further possible explanations of variation: there was variation in how hospitals coded admissions; some systems focused proactively on admission avoidance whereas others were more interested in hospital discharge, for example use of multidisciplinary teams based at acute trusts; there were different levels of integration between different services such as health and social care, and acute and community trusts; and some systems faced more challenging problems around geographical boundaries operating for different services in the system. Interviewees often described admission as the easy or safe option. CONCLUSIONS: Deprivation explained most of the variation in avoidable admission rates. Research is needed to understand the complex relationship between deprivation and avoidable admission, and to develop interventions tailored to avoid admissions from deprived communities. Standardisation of coding of admissions would reduce variation. FUNDING: The National Institute for Health Research Health Service and Research Delivery programme.

O'Meara, P., Burley, M. et Kelly, H. (2002). "Rural urgent care models: what are they made of?" Aust J Rural Health 10(1) : 45-50.

The study aimed to identify the elements that constitute rural urgent care systems. Participation in the study was sought from health professionals, welfare and emergency services sectors, and community members. Primary data were collected from informants through interviews and focus groups in five rural communities of different sizes. Twelve common elements to rural urgent care systems were identified and divided into two categories: (i) infrastructure; and (ii) personnel. Infrastructure included organisational support, community support, transport, communication and coordination processes, facilities and equipment, and community knowledge and information. Personnel included nurses, doctors, community leaders, health and welfare professionals, emergency service workers and ambulance officers. The study's major outcome was the recognition that rural urgent care systems consist of a balance of interrelated elements. These elements are context driven, with geographical, social and economic environments having a substantial impact on the ability of rural communities to develop and sustain their urgent care systems.

Or, Z. et Penneau, A. (2018). "A Multilevel Analysis of the determinants of emergency care visits by the elderly in France." Health Policy 122(8) : 908-914

BACKGROUND : Rising numbers of visits to emergency departments (EDs), especially amongst the elderly, is a source of pressure on hospitals and on the healthcare system. This study aims to establish the determinants of ED visits in France at a territorial level with a focus on the impact of ambulatory care organisation on ED visits by older adults aged 65 years and over. METHODS : We use multilevel regressions to analyse how the organisation of healthcare provision at municipal and wider 'department' levels impacts ED utilisation by the elderly while controlling for the local demographic, socioeconomic and health context of the area in which patients live. RESULTS : ED visits vary significantly by health context and

economic level of municipalities. Controlling for demand-side factors, ED rates by the elderly are lower in areas where accessibility to primary care is high, measured as availability of primary care professionals, out-of-hours care and home visits in an area. Proximity (distance) and size of ED are drivers of ED use. CONCLUSION : High rates of ED visits are partly linked to inadequate accessibility of health services provided in ambulatory settings. Redesigning ambulatory care at local level, in particular by improving accessibility and continuity of primary and social care services for older adults could reduce ED visits and, therefore, improve the efficient use of available healthcare resources.

Pacheco, J., Cuadrado, C. et Martinez-Gutierrez, M. S. (2019). "Urgent care centres reduce emergency department and primary care same-day visits: A natural experiment." Health Policy Plan 34(3) : 170-177.

The aim of this study is to evaluate the impact of urgent care centres' (UCCs) implementation on emergency department (ED) and same-day visits in primary care in a Chilean public healthcare network. Quasi-experimental design study assessing changes in patient visits after UCC implementation in a local health district. Ten family health centres (FHC), nine UCCs and three EDs in the Talcahuano Health District, Chile. A total of 1 603 055 same-day visits to FHC, 1 528 319 visits to UCCs and 1 727 429 visits to EDs, monthly grouped, from 2008 to 2014. Data were obtained from the Monthly Statistical Register Database. We used quasi-experimental methods to evaluate the impact of UCC implementation on ED visits and same-day visits to FHC. We used a difference-in-difference analysis with seasonal adjustments to control potential confounders. We used a triple difference model to test for potential short-term effects. We used as an intervention a group of FHCs and EDs that implemented UCCs from 2008 to 2014 and, as a comparison group, the FHCs and EDs that implemented UCCs before that period. We observed a 5.70% (95% CI: -11.05 to -0.35) decrease in the same-day visits rate to FHCs and a 2.69% (95% CI: -3.96 to -1.43) reduction in ED visits after UCC implementation. The negative trend in same-day visits was more pronounced in children and adolescents (-14.18%; 95% CI: -20.10 to -8.25). The negative trend in ED visits was more pronounced in adult (-4.15%; 95% CI: -5.46 to -2.83) and elderly population (-2.24%; 95% CI: -4.00 to -0.48). We also confirmed that our results are not driven by transient short-term effects after the intervention. UCC implementation reduced ED visits. However, they also reduced same-day visits to primary care centres. This could have a negative impact on the quality of primary care provided.

Pacheco, J., Cuadrado, C. et Martínez-Gutiérrez, M. S. (2019). "Urgent care centres reduce emergency department and primary care same-day visits: A natural experiment." Health Policy and Planning 34(3) : 170-177.
https://doi.org/10.1093/heapol/czz023

The aim of this study is to evaluate the impact of urgent care centres' (UCCs) implementation on emergency department (ED) and same-day visits in primary care in a Chilean public healthcare network. Quasi-experimental design study assessing changes in patient visits after UCC implementation in a local health district. Ten family health centres (FHC), nine UCCs and three EDs in the Talcahuano Health District, Chile. A total of 1 603 055 same-day visits to FHC, 1 528 319 visits to UCCs and 1 727 429 visits to EDs, monthly grouped, from 2008 to 2014. Data were obtained from the Monthly Statistical Register Database. We used quasi-experimental methods to evaluate the impact of UCC implementation on ED visits and same-day visits to FHC. We used a difference-in-difference analysis with seasonal adjustments to control potential confounders. We used a triple difference model to test for potential short-

term effects. We used as an intervention a group of FHCs and EDs that implemented UCCs from 2008 to 2014 and, as a comparison group, the FHCs and EDs that implemented UCCs before that period. We observed a 5.70% (95% CI: −11.05 to −0.35) decrease in the same-day visits rate to FHCs and a 2.69% (95% CI: −3.96 to −1.43) reduction in ED visits after UCC implementation. The negative trend in same-day visits was more pronounced in children and adolescents (−14.18%; 95% CI: −20.10 to −8.25). The negative trend in ED visits was more pronounced in adult (−4.15%; 95% CI: −5.46 to −2.83) and elderly population (−2.24%; 95% CI: −4.00 to −0.48). We also confirmed that our results are not driven by transient short-term effects after the intervention. UCC implementation reduced ED visits. However, they also reduced same-day visits to primary care centres. This could have a negative impact on the quality of primary care provided.

Paschal, D. (2012). "Launching complex medical workups from an urgent care platform." Ann Intern Med 156(3) : 232-233.

The basic parameters for medical workups have scarcely changed in the past 30 years. That is, what the internal medicine community has deemed acceptable for outpatient, inpatient, emergency department, and urgent care evaluation has remained pretty much stable or stagnant during all that time. We are failing to take advantage of the phenomenal speed and accuracy of new laboratory and imaging technologies. Due to Hurricane Katrina, which destroyed the Veterans Administration Hospital in New Orleans, those of us who work in its urgent care clinic were forced to undertake complex medical workups from an 8-to-5, walk-in platform. We have been amazed at the efficiency of this. Workups that used to take weeks can often be done in a few hours or days. What we have discovered here serendipitously may be worth deliberately duplicating elsewhere.

Peterson, L. E., Puffer, J. C., Nasim, U., et al. (2019). "Family Physicians' Contributions to Rural Emergency Care and Urban Urgent Care." J Am Board Fam Med 32(3) : 295-296.

Using 2017 data, we demonstrate a sharp increase in the proportion of family physicians (FPs) working primarily in rural emergency departments and increasing numbers of FPs working in urgent care centers. Despite growth in emergency medicine-trained physicians, FPs are likely to continue to be the backbone of emergency care in rural America.

Pinchbeck, T. (2014). Walk This Way: Estimating Impacts of Walk in Centres at Hospital Emergency Departments in the English National Health Service. Londres Spatial Economics Research Centre http://www.spatialeconomics.ac.uk/textonly/SERC/publications/download/sercdp0041.pdf

In publicly funded health care systems policy-makers face a dilemma: placing low acuity emergency care services outside hospitals may widen access to care and divert patients from making costly hospital visits, but may also attract new patients that have little need for medical care. Using detailed information contained in hospital records, I evaluate the impacts of one type of low acuity service - Walk in Centres (WiCs) in the English National Health Service (NHS) - relying on timing differences in the deployment of a single wave of services and restricting attention to places where new facilities opened to mitigate endogeneity concerns. Results indicate that WiCs have significantly reduced attendances at hospital Emergency Departments in places close by, but suggest that only between 10-20% of patients seen at hospital-based WiCs and between 5-10% patients seen at other WiCs were diverted from the more costly high acuity facilities at hospitals.

Pinchbeck, T. (2019). Convenient Primary Care and Emergency Hospital Utilization. Department of Economics Discussion Paper Series No. 19/04. Londres City University of London

> Participation and utilization decisions lie at the heart of many public policy questions. I contribute new evidence by using hospital records to examine how access to primary care services affects utilization of hospital Emergency Departments in England. Using a natural experiment in the roll out of services, I first show that access to primary care reduces Emergency Departments visits. Additional strategies then allow me to separate descriptively four aspects of primary care access: proximity, opening hours, need to make an appointment, and eligibility. Convenience–oriented services divert three times as many patients from emergency visits, largely because patients can attend without appointments.

Poku, B. A. et Hemingway, P. (2019). "Reducing repeat paediatric emergency department attendance for non-urgent care: A systematic review of the effectiveness of interventions." Emerg Med J 36(7) : 435-442.

> OBJECTIVE: Non-urgent paediatric ED (PED) visits appear to contribute a large portion to the growing use of EDs globally. Several interventions have tried to curb repeated non-urgent attendances, but no systematic review of their effectiveness exists. This review examines the effectiveness of interventions designed to reduce subsequent non-urgent PED visits after a non-urgent attendance. METHOD: A systematic review design. A systematic search of four databases and key journals was conducted from their inception to November 2018. Experimental studies, involving children aged 0-18 years presenting to an ED for non-urgent care, which assessed the effectiveness of interventions on subsequent non-urgent attendance were considered. RESULTS: 2120 studies were identified. Six studies, including four randomised controlled trials (RCTs) and two quasi-experimental, were included. Studies were of moderate quality methodologically. All studies originated from the USA and involved informational and/or follow-up support interventions. Only two RCTs demonstrated the longest duration of intervention effects on reducing subsequent non-urgent PED attendance. These studies identified participants retrospectively after ED evaluation. The RCT with the largest number of participants involved follow-up support by primary physicians. Meta-analysis was impractical due to wide heterogeneity of the interventions. CONCLUSIONS: There is inconclusive evidence to support any intervention aimed at reducing subsequent non-urgent PED visits following a non-urgent attendance. The long-term impact of interventions is limited, although the effect may be maximised if delivered by primary care providers in children identified after their ED attendance. However, further research is required to evaluate the impact of any such strategies in settings outside the USA.

Pope, C., Turnbull, J., Jones, J., et al. (2017). "Has the NHS 111 urgent care telephone service been a success? Case study and secondary data analysis in England." BMJ Open 7(5) : e014815.

> OBJECTIVES: To explore the success of the introduction of the National Health Service (NHS) 111 urgent care service and describe service activity in the period 2014-2016. DESIGN: Comparative mixed method case study of five NHS 111 service providers and analysis of national level routine data on activity and service use. SETTINGS AND DATA: Our primary research involved five NHS 111 sites in England. We conducted 356 hours of non-participant observation in NHS 111 call centres and the urgent care centres and, linked to these observations, held 6 focus group interviews with 47 call advisors, clinical and managerial staff. This primary research is augmented by a secondary analysis of routine data about the 44 NHS 111 sites in England contained in the NHS 111 Minimum Data Set made available by

NHS England. RESULTS: Opinions vary depending on the criteria used to judge the success of NHS 111. The service has been rolled out across 44 sites. The 111 phone number is operational and the service has replaced its predecessor NHS Direct. This new service has led to changes in who does the work of managing urgent care demand, achieving significant labour substitution. Judged against internal performance criteria, the service appears not to meet some targets such as call answering times, but it has seen a steady increase in use over time. Patients appear largely satisfied with NHS 111, but the view from some stakeholders is more mixed. The impact of NHS 111 on other health services is difficult to assess and cost-effectiveness has not been established. CONCLUSION: The new urgent care service NHS 111 has been brought into use but its success against some key criteria has not been comprehensively proven.

Purdy, S. (2010). Avoiding hospital admissions. What does the research evidence say? Londres The King's Fund
http://www.kingsfund.org.uk/publications/avoiding_hospital.html

Ce document analyse les données sur des interventions qui ont pour but d'éviter les admissions à l'hôpital en urgence ou les admissions non planifiées. L'auteur tente de répondre aux questions suivantes : Quels moyens fonctionnent bien pour réduire les admissions évitables ? Qui est à risque et comment identifier ces personnes ? Quelles admissions sont évitables ? Quelles sont les interventions qui agissent pour éviter efficacement les hospitalisations dans les soins de santé primaires, les services sociaux, les soins d'urgence et les sorties d'hôpital ?

Qin, H., Prybutok, G. L., Prybutok, V. R., et al. (2015). "Quantitative comparisons of urgent care service providers." Int J Health Care Qual Assur 28(6) : 574-594.

PURPOSE: The purpose of this paper is to develop, validate, and use a survey instrument to measure and compare the perceived quality of three types of US urgent care (UC) service providers: hospital emergency rooms, urgent care centres (UCC), and primary care physician offices. DESIGN/METHODOLOGY/APPROACH: This study develops, validates, and uses a survey instrument to measure/compare differences in perceived service quality among three types of UC service providers. Six dimensions measured the components of service quality: tangibles, professionalism, interaction, accessibility, efficiency, and technical quality. FINDINGS: Primary care physicians' offices scored higher for service quality and perceived value, followed by UCC. Hospital emergency rooms scored lower in both quality and perceived value. No significant difference was identified between UCC and primary care physicians across all the perspectives, except for interactions. RESEARCH LIMITATIONS/IMPLICATIONS: The homogenous nature of the sample population (college students), and the fact that the respondents were recruited from a single university limits the generalizability of the findings. PRACTICAL IMPLICATIONS: The patient's choice of a health care provider influences not only the continuity of the care that he or she receives, but compliance with a medical regime, and the evolution of the health care landscape. SOCIAL IMPLICATIONS: This work contributes to the understanding of how to provide cost effective and efficient UC services. ORIGINALITY/VALUE: This study developed and validated a survey instrument to measure/compare six dimensions of service quality for three types of UC service providers. The authors provide valuable data for UC service providers seeking to improve patient perceptions of service quality.

Qin, H., Prybutok, V. et Prybutok, G. (2016). "Quantitative comparison of measurements of urgent care service quality." Health Mark Q 33(1) : 59-77.

> Service quality and patient satisfaction are essential to health care organization success. Parasuraman, Zeithaml, and Berry introduced SERVQUAL, a prominent service quality measure not yet applied to urgent care. We develop an instrument to measure perceived service quality and identify the determinants of patient satisfaction/ behavioral intentions. We examine the relationships among perceived service quality, patient satisfaction and behavioral intentions, and demonstrate that urgent care service quality is not equivalent using measures of perceptions only, differences of expectations minus perceptions, ratio of perceptions to expectations, and the log of the ratio. Perceptions provide the best measure of urgent care service quality.

Resnick, L. A. (2013). "Urgent Care: the evolution of a revolution." Isr J Health Policy Res 2(1) : 39. https://ijhpr.biomedcentral.com/articles/10.1186/2045-4015-2-38

> The rapid and global growth of urgent care centers has had a revolutionary, though poorly understood, impact on the health care delivery system. The consumer-driven care model inherent in urgent care and other so-called convenience care models is permeating into more conventional health care models. In addition, physician and hospital payment models are evolving, especially in the United States and are creating new market forces that will impact the organization and importance of integrated health care networks in the future. Together, these transformative changes are creating evolutionary pressures on traditional urgent care. Lessons learned from both the Israeli and American experience can be especially helpful for drafting a successful urgent care model for the future.

Resnick, M. J. (2020). "Re: Postdischarge Unplanned Care Events among Commercially Insured Patients with an Observation Stay versus Short Inpatient Admission." J Urol 203(2) : 242-243.

Reyes, B. J., Lopez, J. M., Galindo, D. J., et al. (2017). "Baseline Characteristics and Outcomes of Older Adults Seeking Care in Ambulatory Urgent Care Clinics." J Am Geriatr Soc 65(12) : 2702-2706.

> OBJECTIVES: To determine the most common clinical conditions associated with older adults visiting Urgent care centers (UCCs) and the potential need for further resource use. DESIGN: Cross-sectional retrospective study. SETTING: Nonprofit academic medical center with campuses and multiple satellite offices in Ohio and Florida. PARTICIPANTS: Individuals aged 55 and older who visited UCCs between August 2014 and March 2015 (N = 9,445; average age 63.1 +/- 10.1, 64% female). Of those, 2,445 had at least one encounter within the same healthcare system within 30 days after the index visit and were included in our final analysis. MEASUREMENTS: 30-day ED visits and hospitalizations. RESULTS: Of the 2,445 patients, 578 (23.6%) visited the emergency department (ED) or were hospitalized, 974 (39.8%) returned to the UCC, and 895 (63.4%) visited their primary care physician's office. A significantly higher proportion (38.4%, n = 68/177) of individuals aged 85 and older visited the ED or were hospitalized within 30 days (P < .010) than of those younger than 65 (20.0%, n = 273/1,367). Diabetes mellitus (odds ratio (OR) = 1.73, 95% confidence interval (CI) = 1.40-2.15, P < .001), coronary artery disease or cerebrovascular disease (OR = 2.45 CI 1.95-3.09, P < .001), chronic obstructive pulmonary disorder or asthma (OR = 1.57, 95% CI = 1.23-2.01, P < .001), polypharmacy (OR = 1.45, 95% CI = 1.18-1.78, P = .004), and cognitive impairment (OR = 2.74, 95% CI = 1.74-4.31, P < .010) were associated with higher rates of ED visits or hospitalizations

within 30 days of the UCC visit. CONCLUSION: Older adults (especially those aged >/=85) and those with conditions such as polypharmacy and dementia are at higher risk of being hospitalized or visit the ED after seeking care at UCCs than younger adults and those without these conditions.

Roland, M. et Boyle, A. A. (2013). "Urgent care in England." BMJ 347 : f7046.

Sabbatini, A. K., Wright, B., Kocher, K., et al. (2019). "Postdischarge Unplanned Care Events Among Commercially Insured Patients With an Observation Stay Versus Short Inpatient Admission." Ann Emerg Med 74(3) : 334-344.

STUDY OBJECTIVE: Observation stays are composing an increasing proportion of unscheduled hospitalizations in the United States, with unclear consequences for the quality of care. This study used a nationally representative data set of commercially insured patients hospitalized from the emergency department (ED) to compare 30-day postdischarge unplanned care events after an observation stay versus a short inpatient admission. METHODS: This was a retrospective analysis of ED hospitalizations using the 2015 Truven MarketScan Commercial Claims and Encounters data set. Adult observation stays and short inpatient hospitalizations of 2 days or less were identified and followed for 30 days from hospital discharge to identify unplanned care events, defined as a subsequent inpatient admission, observation stay, or return ED visit. A propensity score analysis was used to compare rates of unplanned events after each type of index hospitalization. RESULTS: Among the propensity-weighted cohorts, patients with an index observation stay were 28% more likely to experience any unplanned care event within 30 days of discharge compared with those with a short inpatient admission (20.4% versus 15.9%; risk ratio 1.28; 95% confidence interval [CI] 1.21 to 1.34). Specifically, patients in the observation stay group had substantially higher rates of postdischarge observation stays (4.8% versus 1.9%; odds ratio 2.60; 95% CI 2.15 to 3.16) and ED revisits with discharge (11.1% versus 8.8%; odds ratio 1.26; 95% CI 1.21 to 1.44) compared with those in the inpatient group, but were less likely to be readmitted as inpatients (6.4% versus 7.2%; odds ratio 0.90; 95% CI 0.83 to 0.96). CONCLUSION: Commercially insured patients with an observation stay from the ED have a higher risk of postdischarge acute care events compared with similar patients with a short inpatient admission. Additional research is necessary to determine the extent to which quality of care, including care transitions, may differ between these 2 groups.

Sagan, A., Richardson, E., Turner, J., et al. (2015). "Providing emergency medical care." Eurohealth 21(4)
http://www.euro.who.int/__data/assets/pdf_file/0012/294996/EuroHealth_v21_n4.pdf

This issue's Eurohealth Observer section looks at the challenge of providing emergency medical care, including articles on out-of-hours primary care and demand for emergency medical services, urgent care and the English NHS 111 experience, and waiting time policies in the health sector. Other articles include: challenges and concerns in the new era of EU health policy; Variable implementation of eHealth services within the EU; Medicrime Convention to fight against counterfeit medicines; National men's health policies (Ireland); Hospital reforms (Switzerland); and Eurohealth Monitor.

Saghafian, S., Imanirad, R., Traub, S. J., et al. (2018). Who is an Efficient and Effective Physician? Evidence from Emergence Medicine. Faculty Research Working Papers Series ; RWP18-029. Cambridge John F. Kennedy School of Government

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3227873

> Improving the performance of the healthcare sector requires an understanding of the efficiency and effectiveness of care delivered by providers. Although this topic is of great interest to policymakers, researchers, and hospital managers, fair and scientific methods of measuring efficiency and effectiveness of care delivery have proven elusive. Through Data Envelopment Analysis (DEA), we make use of evidence from care delivered by emergency physicians, and shed light on scientific metrics that can gauge performance in terms of efficiency and effectiveness. We use these metrics along with Machine Learning techniques and Tobit analyses to identify the distinguishing behaviors of physicians who perform highly on these metrics. Our findings indicate a statistically significant positive relationship between a physician's effectiveness and efficiency scores suggesting that, contrary to conventional wisdom, high levels of effectiveness are not necessarily associated with low efficiency levels. In addition, we find that a physician's effectiveness is positively associated with his/her average contact-to-disposition time and negatively associated with his/her years of experience. We also find a statistically significant negative relationship between a physician's efficiency and his/her average MRI orders per patient visit. Furthermore, we find evidence of a peer effect of one physician upon another, which suggests an opportunity to improve system performance by taking physician characteristics into account when determining the set of physicians that should be scheduled during same shifts.

Scapinello, M. P., Posocco, A., De Ronch, I., et al. (2016). "Predictors of emergency department referral in patients using out-of-hours primary care services." Health Policy 120(9) : 1001-1007. http://dx.doi.org/10.1016/j.healthpol.2016.07.018

> ?Overcrowding the emergency department (ED) for non-urgent patients is a common problem, but strategies to decrease it are poorly studied.?Our study suggests that out-of-hours (OOH) service could be a filter to decrease ED access.?Our study shows some relevant conditions that increase the probability of being referred to ED from OOH primary care service.

Scott, D. R., Batal, H. A., Majeres, S., et al. (2009). "Access and care issues in urban urgent care clinic patients." BMC Health Serv Res 9 : 222.

> BACKGROUND: Although primary care should be the cornerstone of medical practice, inappropriate use of urgent care for non-urgent patients is a growing problem that has significant economic and healthcare consequences. The characteristics of patients who choose the urgent care setting, as well as the reasoning behind their decisions, is not well established. The purpose of this study was to determine the motivation behind, and characteristics of, adult patients who choose to access health care in our urgent care clinic. The relevance of understanding the motivation driving this patient population is especially pertinent given recent trends towards universal healthcare and the unclear impact it may have on the demands of urgent care. METHODS: We conducted a cross-sectional survey of patients seeking care at an urgent care clinic (UCC) within a large acute care safety-net urban hospital over a six-week period. Survey data included demographics, social and economic information, reasons that patients chose a UCC, previous primary care exposure, reasons for delaying care, and preventive care needs. RESULTS: A total of 1, 006 patients were randomly surveyed. Twenty-five percent of patients identified Spanish as their preferred language. Fifty-four percent of patients reported choosing the UCC due to not having to make an appointment, 51.2% because it was convenient, 43.9% because of same day test results,

42.7% because of ability to get same-day medications and 15.1% because co-payment was not mandatory. Lack of a regular physician was reported by 67.9% of patients and 57.2% lacked a regular source of care. Patients reported delaying access to care for a variety of reasons. CONCLUSION: Despite a common belief that patients seek care in the urgent care setting primarily for economic reasons, this study suggests that patients choose the urgent care setting based largely on convenience and more timely care. This information is especially applicable to the potential increase in urgent care volume in a universal healthcare system. Additionally, this study adds to the body of literature supporting the important role of timely primary care in healthcare maintenance.

Shen, Y. C. et Hsia, R. Y. (2011). Does Decreased Access to Emergency Departments Affect Patient Outcomes? Analysis of AMI Population 1996-2005. NBER Working Paper Series n° 16690. Cambridge NBER
http://www.nber.org/papers/w16690

We analyze whether decreased emergency department access (measured by increased driving time to the nearest ED) results in adverse patient outcomes or changes in the patient health profile for patients suffering from acute myocardial infarction. Data sources include 100% Medicare Provider Analysis and Review, AHA hospital annual surveys, Medicare hospital cost reports, and longitude and latitude information for 1995-2005. We define four ED access change categories and estimate a zip codes fixed-effects regression models on the following AMI outcomes: time-specific mortality rates, age, and probability of PTCA on the day of admission. We find a small increase in 30-day to 1-year mortality rates among patients in communities that experience <10-minute increase in driving time. Among patients in communities with >30-minute increases in driving time, we find a substantial increase in long-term mortality rates, a shift to younger ages (suggesting that the older ones die en route) and a higher probability of immediate PTCA. Most of the adverse effects disappear after the initial three-year transition window.

Shen, Y. C. et Hsia, R. Y. (2016). Geographical Distribution of Emergency Department Closures and Consequences on Heart Attack Patients. NBER Working Paper series n° 22861. Cambridge NBER
www.nber.org/papers/w22861

We develop a conceptual framework and empirically investigate how a permanent emergency department (ED) closure affects patients with acute myocardial infarction (AMI). We first document that large increases in driving time to closest ED are more likely to happen in low-income communities and communities that had fewer medical resources at baseline. Then using a difference-in-differences design, we estimate the effect of an ED closure on access to cardiac care technology, treatment, and health outcomes among Medicare patients with AMI who lived in 24,567 ZIP codes that experienced no change, an increase of <10 minutes, 10 to <30 minutes, and =30 minutes in driving time to their closest ED. Overall, access to cardiac care declined in all communities experiencing a closure, with access to a coronary care unit decreasing by 18.64 percentage points (95% CI -30.15, -7.12) for those experiencing =30-minute increase in driving time. Even after controlling for access to technology and treatment, patients with the longest delays experienced a 6.58 (95% CI 2.49, 10.68) and 6.52 (95% CI 1.69, 11.35) percentage point increase in 90-day and 1-year mortality, respectively, compared with those not experiencing changes in distance. Our results also suggest that the predominant mechanism behind the mortality increase appeared to be time delay as opposed to availability of specialized cardiac treatment.

Simpson, R. M., Stone, T., Conroy, S. P., et al. (2018). "Increased Urgent Care Center Visits by Southeast European Migrants: A Retrospective, Controlled Trial from Switzerland." Emerg Med J 15(9).

> We investigated whether immigrants from Southeast Europe (SE) and Swiss patients have different reasons for visiting the emergency department (ED). Our retrospective data analysis for the years 2013(-)2017 describes the pattern of ED consultations for immigrants from SE living in Switzerland (Canton Bern), in comparison with Swiss nationals, with a focus on type of referral and reason for admission. A total of 153,320 Swiss citizens and 12,852 immigrants from SE were included in the study. The mean age was 51.30 (SD = 21.13) years for the Swiss patients and 39.70 (SD = 15.87) years for the SE patients. For some countries of origin (Albania, Bosnia and Herzegovina, and Turkey), there were highly statistically significant differences in sex distribution, with a predominance of males. SE immigrants had a greater proportion of patients in the lower triage level (level 3: SE: 67.3% vs. Swiss: 56.0%) and a greater proportion of patients in the high triage level than the Swiss population (level 1: SE: 3.4% vs. Swiss: 8.8%). SE patients of working age (16(-)65 years) were six times more often admitted by ambulance than older (>/=65 years) SE patients, whereas this ratio was similar in the Swiss population. In both groups, the fast track service was primarily used for patients of working age (<65) and more than three times more often in the SE than the Swiss group (SE: 39.1%, Swiss: 12.6%). We identified some indications for access to primary care in emergency departments for immigrants and highlighted the need for attention to the role of organizational characteristics of primary health care in Switzerland. We highlighted the need for professional support to improve the quality of healthcare for immigrants. In the future, we will need more primary care services and general practitioners with a migrant background.

Smits, M., Colliers, A., Jansen, T., et al. (2019). "Examining differences in out-of-hours primary care use in Belgium and the Netherlands: a cross-sectional study." European Journal of Public Health 29(6) : 1018-1024.
https://doi.org/10.1093/eurpub/ckz083

> The organizational model of out-of-hours primary care is likely to affect healthcare use. We aimed to examine differences in the use of general practitioner cooperatives for out-of-hours care in the Netherlands and Belgium (Flanders) and explore if these are related to organizational differences.A cross-sectional observational study using routine electronic health record data of the year 2016 from 77 general practitioner cooperatives in the Netherlands and 5 general practitioner cooperatives in Belgium (Flanders). Patient age, gender and health problem were analyzed using descriptive statistics.The number of consultations per 1000 residents was 2.3 times higher in the Netherlands than in Belgium. Excluding telephone consultations, which are not possible in Belgium, the number of consultations was 1.4 times higher. In Belgium, the top 10 of health problems was mainly related to infections, while in the Netherlands there were a larger variety of health problems. In addition, the health problem codes in the Dutch top 10 were more often symptoms, while the codes in the Belgian top 10 were more often diagnoses. In both countries, a relatively large percentage of GPC patients were young children and female patients.Differences in the use of general practitioner cooperatives seem to be related to the gatekeeping role of general practitioners in the Netherlands and to organizational differences such as telephone triage, medical advice by telephone, financial thresholds and number of years of experience with the system. The information can benefit policy decisions about the organization of out-of-hours primary care.

Sorensen, B. S., Zane, R. D. et Wante, B. E. (2011). Hospital emergency response check-list : an all-hazards tool for hospital administrators and emergency managers. Copenhague OMS Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0020/148214/e95978.pdf

> Hospitals play a critical role in providing communities with essential medical care during all types of disaster. Depending on their scope and nature, disasters can lead to a rapidly increasing service demand that can overwhelm the functional capacity and safety of hospitals and the health-care system at large. The World Health Organization Regional Office for Europe has developed the Hospital emergency response checklist to assist hospital administrators and emergency managers in responding effectively to the most likely disaster scenarios. This tool comprises current hospital-based emergency management principles and best practices and integrates priority action required for rapid, effective response to a critical event based on an all-hazards approach. The tool is structured according to nine key

Southern, L., Leahey, M., Harper-Jaques, S., et al. (2007). "Integrating mental health into urgent care in a community health centre." Can Nurse 103(1) : 29-34.

> Competent, convenient mental health assessment and psychosocial intervention are seldom delivered in the right place, at the right time and by the right person. One solution to this problem is to have mental health services integrated into urgent care in a community health centre. Unfortunately, although there is literature on urgent care centres, mental health centres and psychiatric emergency rooms, there is scant information about the integration of mental health services into an urgent care centre.

StationeryOffice (2007). The provision of out-of-hours care in England. Londres The stationery office limited
https://www.nao.org.uk/wp-content/uploads/2006/05/05061041.pdf

> Approximately 9 million patients receive urgent primary out-of-hours care in England every year. The term out-of-hours care refers to care delivered between 6:30 pm and 8:00 am on weekdays and at all times during weekends and public holidays. Prior to April 2004 GPs were responsible for the provision of this care, but most provided the service either by pooling their responsibility through a GP co-operative or delegating it to a commercial deputising service. Responsibility for this service had become unpopular with GPs and there were rising levels of complaints from patients. With effect from April 2004 the Department of Health gave GPs the chance to opt out of personal responsibility for the service under a new General Medical Services contract agreed with the medical profession. Where a GP opted out, he or she gave up an average of £6,000 per year and the local Primary Care Trust took over responsibility for the out-of hours service for the GP's patients. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department on three main issues: the Department's preparation for the new out-of hours service; the performance of the new service; and its costs.1We found that preparations for the new service were shambolic, both at the national and local level. The Department took part in the negotiation of the new General Medical Services contract only as an observer, and only the doctors did well out of the deal on outof- hours costs. The Department also failed to explain whether the service should be for urgent care or all unscheduled health needs. The new service is undoubtedly now starting to improve. But actual performance against the key access targets is still not good enough. The percentage of providers meeting the requirements for call answering, definitive clinical assessment and consultation times is extremely low. For

example only 2% could report that they complied with one standard. Some providers were simply unable to report at all. The cost of the new out-of-hours service has also been some £70 million a year higher than foreseen.

Stempniak, M. (2015). "URGENT CARE 2.0 The evolution of an old model." Hosp Health Netw 89(5) : 32-35.

Sturgeon, D. (2017). "Convenience, quality and choice: Patient and service-provider perspectives for treating primary care complaints in urgent care settings." Int Emerg Nurs 35 : 43-50.

AIM: To investigate why patients chose to attend two, nurse-led, minor injury units (MIUs) to access primary healthcare services rather than attend their GP practice. BACKGROUND: Since the 1980's, healthcare organisations in the UK and elsewhere have implemented an increasingly consumer-orientated model of healthcare provision. As a result, patients with non-urgent presentations are attending Emergency Departments (EDs) and other urgent care facilities in growing numbers. METHODS: A comparative case study approach was adopted and between October 2014 and May 2015 the researcher was embedded as a participant observer as part of the emergency nurse practitioner team at two, nurse-led, MIUs (site A and B). During this time, 40 patients, 17 service-providers and 1 senior manager were interviewed. RESULTS: Patients and service-providers at both sites identified convenience and quality of care as the principle reasons patients presented for primary healthcare services at MIUs rather than their GP practice. Service-providers were aware that by providing treatment, they established a precedent and a sense of expectation for future care. CONCLUSION: Patients are acting rationally and predictably in response to healthcare policy promises regarding choice, expectation created by service-providers, and local demographic factors.

Tang, F., Xiao, C., Wang, F., et al. (2018). "Predictive modeling in urgent care: A comparative study of machine learning approaches." JAMIA Open 1(1) : 87-98.

Objective: The growing availability of rich clinical data such as patients' electronic health records provide great opportunities to address a broad range of real-world questions in medicine. At the same time, artificial intelligence and machine learning (ML)-based approaches have shown great premise on extracting insights from those data and helping with various clinical problems. The goal of this study is to conduct a systematic comparative study of different ML algorithms for several predictive modeling problems in urgent care. Design: We assess the performance of 4 benchmark prediction tasks (eg mortality and prediction, differential diagnostics, and disease marker discovery) using medical histories, physiological time-series, and demographics data from the Medical Information Mart for Intensive Care (MIMIC-III) database. Measurements: For each given task, performance was estimated using standard measures including the area under the receiver operating characteristic (AUC) curve, F-1 score, sensitivity, and specificity. Microaveraged AUC was used for multiclass classification models. Results and Discussion: Our results suggest that recurrent neural networks show the most promise in mortality prediction where temporal patterns in physiologic features alone can capture in-hospital mortality risk (AUC > 0.90). Temporal models did not provide additional benefit compared to deep models in differential diagnostics. When comparing the training-testing behaviors of readmission and mortality models, we illustrate that readmission risk may be independent of patient stability at discharge. We also introduce a multiclass prediction scheme for length of stay which

preserves sensitivity and AUC with outliers of increasing duration despite decrease in sample size.

Torjesen, I. (2008). "Out of hours standards to be applied to urgent care." Health Serv J: 12.

Triggle, N. (2013). "Community nurses can reduce strain on urgent care staff." Emerg Nurse 21(7) : 8.

Turnbull, J., McKenna, G., Prichard, J., et al. (2019). Health Services and Delivery Research. Sense-making strategies and help-seeking behaviours associated with urgent care services: a mixed-methods study. Southampton (UK), NIHR Journals Library

BACKGROUND: Policy has been focused on reducing unnecessary emergency department attendances by providing more responsive urgent care services and guiding patients to 'the right place'. The variety of services has created a complex urgent care landscape for people to access and navigate. OBJECTIVES: To describe how the public, providers and policy-makers define and make sense of urgent care; to explain how sense-making influences patients' strategies and choices; to analyse patient 'work' in understanding, navigating and choosing urgent care; to explain urgent care utilisation; and to identify potentially modifiable factors in decision-making. DESIGN: Mixed-methods sequential design. SETTING: Four counties in southern England coterminous with a NHS 111 provider area. METHODS: A literature review of policy and research combined with citizens' panels and serial qualitative interviews. Four citizens' panels were conducted with the public, health-care professionals, commissioners and managers (n = 41). Three populations were sampled for interview: people aged >/= 75 years, people aged 18-26 years and East European people. In total, 134 interviews were conducted. Analyses were integrated to develop a conceptual model of urgent care help-seeking. FINDINGS: The literature review identified some consensus between policy and provider perspectives regarding the physiological factors that feature in conceptualisations of urgent care. However, the terms 'urgent' and 'emergency' lack specificity or consistency in meaning. Boundaries between urgent and emergency care are ill-defined. We constructed a typology that distinguishes three types of work that take place at both the individual and social network levels in relation to urgent care sense-making and help-seeking. Illness work involves interpretation and decision-making about the meaning, severity and management of physical symptoms and psychological states, and the assessment and management of possible risks. Help-seeking was guided by moral work: the legitimation and sanctioning done by service users. Navigation work concerned choosing and accessing services and relied on prior knowledge of what was available, accessible and acceptable. From these empirical data, we developed a model of urgent care sense-making and help-seeking behaviour that emphasises that work informs the interaction between what we think and feel about illness and the need to seek care (sense-making) and action - the decisions we take and how we use urgent care (help-seeking). LIMITATIONS: The sample population of our three groups may not have adequately reflected a diverse range of views and experiences. The study enabled us to capture people's views and self-reported service use rather than their actual behaviour. CONCLUSIONS: Much of the policy surrounding urgent and emergency care is predicated on the notion that 'urgent' sits neatly between emergency and routine; however, service users in particular struggle to distinguish urgent from emergency or routine care. Rather than focusing on individual sense-making, future work should attend to social and temporal contexts that have an impact on help-seeking (e.g. why people find it more difficult to manage pain at night), and how different social networks shape service use. FUTURE WORK: A whole-systems approach considering integration across a wider network of partners is key to understanding the complex relationships between demand for and access to urgent care.

STUDY REGISTRATION: This study is registered as UKCRN 32207. FUNDING: The National Institute for Health Research Health Services and Delivery Research programme.

Turnbull, J., Prichard, J., Halford, S., et al. (2012). "Reconfiguring the emergency and urgent care workforce: mixed methods study of skills and the everyday work of non-clinical call-handlers in the NHS." J Health Serv Res Policy 17(4) : 233-240.

OBJECTIVES: To examine the skills and expertise required and used by non-clinical call-handlers doing telephone triage and assessment, supported by a computer decision support system (CDSS) in urgent and emergency care services. METHODS: Comparative case study of three different English emergency and urgent care services. Data consisted of nearly 500 hours of non-participant observation, 61 semi-structured interviews with health service staff, documentary analysis, and a survey of 106 call-handlers. RESULTS: Communication skills and 'allowing the CDSS to drive the assessment' are viewed by the CDSS developers and staff as key competencies for call-handling. Call-handlers demonstrated high levels of experience, skills and expertise in using the CDSS. These workers are often portrayed simply as 'trained users' of technology, but they used a broader set of skills including team work, flexibility and 'translation'. Call-handlers develop a 'pseudo-clinical' expertise and draw upon their experiential knowledge to bring the CDSS into everyday use. CONCLUSIONS: Clinical assessment and triage by non-clinical staff supported by a CDSS represents a major change in urgent and emergency care delivery, warranting a detailed examination of call-handlers' skills and expertise. We found that this work appears to have more in common with clinical work and expertise than with other call-centre work that it superficially resembles. Recognizing the range of skills call-handlers demonstrate and developing a better understanding of this should be incorporated into the training for, and management of, emergency and urgent care call-handling.

Uthman, O. A., Walker, C., Lahiri, S., et al. (2018). "General practitioners providing non-urgent care in emergency department: A natural experiment." BMJ Open 8(5) : e019736.

OBJECTIVE: To examine whether care provided by general practitioners (GPs) to non-urgent patients in the emergency department differs significantly from care provided by usual accident and emergency (A&E) staff in terms of process outcomes and A&E clinical quality indicators. DESIGN: Propensity score matched cohort study. SETTING: GPs in A&E colocated within the University Hospitals Coventry and Warwickshire NHS Trust between May 2015 and March 2016. PARTICIPANTS: Non-urgent attendances visits to the A&E department. MAIN OUTCOMES: Process outcomes (any investigation, any blood investigation, any radiological investigation, any intervention, admission and referrals) and A&E clinical indicators (spent 4 hours plus, left without being seen and 7-day reattendance). RESULTS: A total of 5426 patients seen by GPs in A&E were matched with 10 852 patients seen by emergency physicians (ratio 1:2). Compared with standard care in A&E, GPs in A&E significantly: admitted fewer patients (risk ratio (RR) 0.28, 95% CI 0.25 to 0.31), referred fewer patients to other specialists (RR 0.31, 95% CI 0.24 to 0.40), ordered fewer radiological investigations (RR 0.38, 95% CI 0.34 to 0.42), ordered fewer blood tests (0.57, 95% CI 0.52 to 0.61) and ordered fewer investigations (0.93, 95% CI 0.90 to 0.96). However, they intervened more, offered more primary care follow-up (RR 1.78, 95% CI 1.67 to 1.89) and referred more patients to outpatient and other A&E clinics (RR 2.29, 95% CI 2.10 to 2.49). Patients seen by GPs in A&E were on average less likely to spend 4 hours plus in A&E (RR 0.37, 95% CI 0.30 to 0.45) compared with standard care in A&E. There was no difference in reattendance after 7 days (RR 0.96, 95% CI 0.84 to 1.09). CONCLUSION: GPs in A&E tended to manage self-reporting

minor cases with fewer resources than standard care in A&E, without increasing reattendance rates.

Van den Heede, K., Quentin, W., Dubois, C., et al. (2017). "The 2016 proposal for the reorganisation of urgent care provision in Belgium: A political struggle to co-locate primary care providers and emergency departments." Health Policy 121(4) : 339-345.

Internationally the number of emergency department (ED) visits is on the rise while evidence suggests that a substantial proportion of these patients do not require emergency care but primary care. This paper presents the Belgian 2016 proposal for the reorganisation of urgent care provision and places it into its political context. The proposal focused on re-designing patient flow aiming to reduce inappropriate ED visits by improving guidance of patients through the system. Initially policymakers envisaged, as cornerstone of the reform, to roll-out as standard model the co-location of primary care centres and EDs. Yet, this was substantially toned down in the final policy decisions mainly because GPs strongly opposed this model (because of increased workload and loss of autonomy, hospital-centrism, etc.). In fact, the final compromise assures a great degree of autonomy for GPs in organising out-of-hours care. Therefore, improvements will depend on future developments in the field and continuous monitoring of (un-)intended effects is certainly indicated. This policy process makes clear how important it is to involve all relevant stakeholders as early as possible in the development of a reform proposal to take into account their concerns, to illustrate the benefits of the reform and ultimately to gain buy-in for the reform.

Villasenor, S. et Krouse, H. J. (2016). "Can the use of urgent care clinics improve access to care without undermining continuity in primary care?" J Am Assoc Nurse Pract 28(6) : 335-341.

PURPOSE: There is a niche for urgent care clinics as an alternate source of health care in the United States. This systematic review examines whether the use of urgent care clinics can improve access to care or if these facilities undermine continuity of primary care. DATA SOURCES: Databases used were Cumulative Index for Nursing and Allied Health (CINAHL) and Medical Literature Analysis and Retrieval System Online (MEDLINE). Articles from 2004 to 2014 were searched using keywords-access, barriers, continuity of care, nurse practitioner (NP), urgent care, retail clinic, emergency, and primary care. CONCLUSIONS: Urgent care clinics can improve access to care, but may also negatively impact continuity of care, preventative services, and ongoing management of chronic conditions. Barriers to primary care and benefits of urgent care are inversely related. Insufficient knowledge regarding navigation of the healthcare system, perceived urgency of medical need, and deflection of care contribute to use of urgent care over primary care. IMPLICATIONS FOR PRACTICE: NPs are frontline healthcare providers essential to developing and maintaining successful communication and collaboration among providers across healthcare settings. In both primary care and urgent care facilities, NPs can ensure continuity of care, decreased healthcare costs, and optimized health outcomes for patients.

Way, R. (2008). "Learning from older people who use urgent care services." Emerg Nurse 16(2) : 20-22.

Weinick, R. M., Bristol, S. J. et DesRoches, C. M. (2009). "Urgent care centers in the U.S.: findings from a national survey." BMC Health Serv Res 9 : 79.

BACKGROUND: Due to long waits for primary care appointments and extended emergency department wait times, newer sites for episodic primary care services, such as urgent care centers, have developed. However, little is known about these centers. The purpose of this study is to provide information about the organization and functioning of urgent care centers based on a nationally representative U.S. sample. METHODS: We conducted a mail survey with telephone follow-up of urgent care centers identified via health insurers' websites, internet searches, and a trade association mailing list. Descriptive statistics are presented. RESULTS: Urgent care centers are open beyond typical office hours, and their scope of services is broader than that of many primary care offices. While these characteristics are similar to hospital emergency departments, such centers employ significant numbers of family physicians. The payer distribution is similar to that of primary care, and physicians' average salaries are comparable to those for family physicians overall. Urgent care centers report early adoption of electronic health records, though our findings are qualified by a lack of strictly comparable data. CONCLUSION: While their hours and scope of services reflect some characteristics of emergency departments, urgent care centers are in many ways similar to family medicine practices. As the health care system evolves to cope with expanding demands in the face of limited resources, it is unclear how patients with episodic care needs will be treated, and what role urgent care centers will play in their care.

Weinick, R. M., Burns, R. M. et Mehrotra, A. (2010). "Many emergency department visits could be managed at urgent care centers and retail clinics." Health Aff (Millwood) 29(9) : 1630-1636.

Americans seek a large amount of nonemergency care in emergency departments, where they often encounter long waits to be seen. Urgent care centers and retail clinics have emerged as alternatives to the emergency department for nonemergency care. We estimate that 13.7-27.1 percent of all emergency department visits could take place at one of these alternative sites, with a potential cost savings of approximately $4.4 billion annually. The primary conditions that could be treated at these sites include minor acute illnesses, strains, and fractures. There is some evidence that patients can safely direct themselves to these alternative sites. However, more research is needed to ensure that care of equivalent quality is provided at urgent care centers and retail clinics compared to emergency departments.

Wennman, I., Wittholt, M., Carlstrom, E., et al. (2019). "Urgent care centre in Sweden-the integration of teams and perceived effects." 34(4) : 1205-1216.

An urgent care centre (UCC) is an upcoming trend in Swedish health care. Although UCCs have been established in other countries, their effectiveness and value have not yet been studied in Sweden. The aim of this study was to investigate the interaction between the UCC and emergency department (ED) by using validated evaluation models. One adult ED (AED) and one child ED (CED), together with a newly established UCC nearby, were included in this study. The interaction between the UCC team and the ED teams was studied by using two evaluation models: one for evaluation of integration and the other one for the evaluation of the effects, in terms of perceived relief of the ED after the establishment of the UCC. It was evident that integration was achieved early on in the course of the follow-up. However, the perception of integration varied between low (EDs) and high collaboration (UCC). All respondents of the EDs indicated relief, in terms of pace and pressure on the ED since the UCC was established. This study indicates that the grade of integration and collaboration between UCC and ED can be achieved automatically and very early during the establishment. It also shows that UCCs can be a competent complement to EDs and alleviate some of the heavy pressure placed on EDs due to ED overcrowding.

Wilson, L. (2017). "Urgent care embraces telehealth More centers see advantages of virtual services." Health Data Manag 25(2) : 38-40.

Wilson, T. (2001). "Demands for urgent care." Br J Gen Pract **51**(464) : 231-232.

Wong, C. A., Bain, A., Polsky, D., et al. (2017). "The Use and Out-of-Pocket Cost of Urgent Care Clinics and Retail-Based Clinics by Adolescents and Young Adults Compared With Children." J Adolesc Health 60(1) : 107-112.

PURPOSE: We describe the use and out-of-pocket cost of urgent care clinics (UCCs) and retail-based clinics (RBCs) as ambulatory care alternatives to physician offices among children, adolescents, and young adults, and examine differences in use by age. METHODS: Cross-sectional analysis describing diagnoses and out-of-pocket costs for 8.9 million UCC, RBC, and physician office encounters by privately insured child (aged <11 years), adolescent (aged 11-18 years), and young adult (aged 19-30 years) beneficiaries in a U.S. national administrative data set from January to June 2013. We calculate relative odds (RO) of UCC and RBC utilization by adolescents and young adults, using physician office encounters and children as reference groups. RESULTS: UCC (n = 286,144) and RBC (n = 89,903) visits were <5% of encounters. Upper respiratory infections were the most common diagnosis at UCCs (children 25.2%, adolescents 27.3%, young adults 26.5%) and RBCs (38.1%, 44.1%, 42.0%). The mean out-of-pocket cost was higher for UCCs (children +$38, adolescents +$29, young adults +$25) and lower for RBCs (-$4, -$15, -$18) compared with physician office encounters. For adolescents, the adjusted relative probability of UCC or RBC versus physician office encounters was 9% higher (RO = 1.09, 95% confidence interval [CI] = 1.08-1.10) and 31% higher (RO = 1.31, 95% CI = 1.29-1.34), respectively, compared with children. For young adults, the adjusted relative probability of a UCC or RBC encounter was 54% (RO = 1.54, 95% CI = 1.52-1.55) and 68% (RO = 1.68, 95% CI = 1.65-1.71) higher, respectively. CONCLUSIONS: Adolescents and young adults were more likely to visit RBCs and UCCs than children. Understanding of UCC and RBC use, cost, and quality of care is needed to inform policies on their roles in health care.

Youd, J. (2015). "Workforce planning for urgent care services." Emerg Nurse 23(4) : 14-19.

Due to major changes in how emergency care is delivered across different communities, one emergency department is no longer like another. Some have separate minor injury provision, some are general departments that cater for all types of patient, while others are designated major trauma centres. These differences in patient profile affect the required numbers and skill mix of nursing establishments so that the nursing workforce in each cannot be predicated on patient numbers alone. This article describes the development by the RCN Emergency Care Association of an evidence-based staffing tool and how it can be used in practice.

Yuill, J. (2018). "The role and experiences of advanced nurse practitioners working in out of hours urgent care services in a primary care setting." Nurs Manag (Harrow) 25(2) : 18-23.

GPs' workload has increased significantly in recent years affecting their ability to provide high-quality services, and consequently there is increasing focus on nurses to provide a solution. There is little evidence of how advanced nurse practitioners (ANPs) experience their role in out of hours (OOH) services, and it is important to understand their perceptions of this and the challenges they may face in supporting service development and improvement.

This article evaluates the role and experiences of ANPs working in an OOH urgent primary care service and identifies important factors that affect their roles. Positive factors enable job satisfaction, but challenges associated with knowledge base, perceptions, role definitions and isolation must be considered for quality and governance purposes. The article describes how supportive systems must be in place to enable mentorship, supervision programmes and development of this group of advanced practitioners.

Zitek, T., Tanone, I., Ramos, A., et al. (2018). "Most Transfers from Urgent Care Centers to Emergency Departments Are Discharged and Many Are Unnecessary." J Emerg Med 54(6) : 882-888.

BACKGROUND: Urgent care centers (UCCs) can offer a cheap alternative to emergency departments (EDs) for some patients with acute complaints. However, if patients who initially present to a UCC are unnecessarily transferred to an ED, those patients may suffer undue financial harm. The group of patients transferred from UCCs to EDs have never previously been studied. OBJECTIVES: The primary objective of this study was to determine the fraction of transfers from a UCC to an ED that were unnecessary. We also assessed the frequency with which these patients were discharged from the ED, and tried to determine which groups of patients were most likely to be unnecessarily transferred. METHODS: This was a retrospective chart review performed on patients transferred from UCCs to our ED. If the transferred patient had no advanced imaging tests, advanced procedures, or specialty consultations in the ED, and was not admitted, we considered the transfer to be unnecessary. Patients were stratified by age (adult vs. pediatric) and type of insurance. RESULTS: We identified 3232 patients who were transferred from UCCs to our ED over a 1-year period. Among those, 1159 (35.9%; 95% confidence interval [CI] 34.2-37.5%) met our criteria as unnecessary, and 2075 (64.2%; 95% CI 62.5-65.8%) were discharged from the ED. Notably, pediatric patients were more likely than adult patients to be unnecessarily transferred. Patients without medical insurance were not more likely to be transferred than those with private insurance. CONCLUSION: Most patients transferred to our ED from a UCC were discharged, and many transfers were unnecessary, especially those involving pediatric patients. These transfers may represent an economic burden to our society.

Motifs de recours aux urgences hospitalières : patientèle et expérience des patients

ÉTUDES FRANÇAISES

ORS (2017). Fréquence des soins non programmés en médecine générale en France aux heures d'ouverture des cabinets de ville. Revue de littérature, Nantes : ORS

Après une définition des soins non programmés, le champ de cette revue de littérature couvre une partie des recours urgents ou non programmés, à savoir les soins non programmés en médecine générale réalisés aux heures d'ouverture habituelles des cabinets, c'est-à-dire en dehors de celles de la permanence des soins. Cette revue de littérature exclut donc également les travaux portant sur les variations saisonnières (qu'il s'agisse de saisons touristiques ou périodes épidémiques).

(1998). "Urgences réelles ou ressenties : une enquête de l'Union Professionnelle des médecins libéraux." Sante - Pays De La Loire (25)

> L'Union Professionnelle des Médecins Libéraux des Pays de la Loire a réalisé une enquête, de juillet 1996 à juillet 1997, sur la prise en charge des urgences dans le secteur de Fontenay-le-Comte, avec le concours des médecins libéraux du secteur, du service d'accueil d'urgences du centre hospitalier de Fontenay-le-Comte ainsi que de la clinique. Près de 6 000 interventions d'urgence ont été enregistrées et analysées, par type d'intervenant, par pathologie, par gravité, par jour de survenue (dans la semaine).

Baubeau, D. et Carrasco, V. (2003). "Motifs et trajectoires de recours aux urgences hospitalières." Etudes Et Résultats (215)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er215.pdf

> L'enquête réalisée en janvier 2002 auprès d'un échantillon de près de 10 000 patients ayant fréquenté les services d'urgence hospitaliers a permis de faire apparaître des types de recours, de pathologies et de prises en charge fortement différenciés en fonction de l'âge (cf Études et résultats, n° 212, janvier 2003 « Les usagers des urgences. Premiers résultats d'une enquête nationale »). De manière à compléter les informations recueillies auprès des équipes soignantes, des interviews téléphoniques ont été réalisées auprès de 3 000 de ces usagers non hospitalisés. Ces entretiens visent à mieux appréhender les caractéristiques de ces patients, les trajectoires qu'ils ont suivies avant leur arrivée aux urgences et les motifs qui les ont amenés à y recourir. Les patients ont également été interrogés sur le déroulement de la prise en charge aux urgences et leur connaissance des autres dispositifs susceptibles de répondre à une demande de soins non programmés.

Baubeau, D., Deville, A., Joubert, M., et al. (2000). "Les passages aux urgences de 1990 à 1998 : une demande croissante de soins non programmés." Etudes Et Résultats (72)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er072.pdf

> Les statistiques présentées dans ce document ne portent que sur deux indicateurs que sont : le nombre des passages aux urgences hospitalières et l'activité de la médecine de ville pour des soins non programmés, les visites à domicile. Les auteurs analysent la fréquentation des

unités d'urgences hospitalières, le recours aux visites à domicile, les disparités régionales de fréquentation des urgences....

Berraho, M., Tachfouti, N., Elmajjaoui, A., et al. (2012). "Les consultations non appropriées aux services des urgences : étude dans un hôpital provincial au Maroc." Pratiques Et Organisation Des Soins (3) : 197-204.
https://www.ameli.fr/fileadmin/user_upload/documents/POS1203_Consultations_non_appropriees_aux_urgences.pdf

[BDSP. Notice produite par CNAMTS IGn8R0x8. Diffusion soumise à autorisation]. Le recours non approprié aux services des urgences diminue la qualité des prestations. Notre objectif était de déterminer les facteurs associés au recours non approprié à ces services. L'étude a été réalisée dans le service des urgences du Centre hospitalier provincial de Nador, durant trois semaines. L'information a été recueillie sur un questionnaire. La définition de la consultation appropriée ou non s'est basée sur le caractère urgent ou non, le jour de la consultation (ouvrable ou férié), le moment de la consultation (jour/nuit) et sur l'ancienneté des symptômes. Cette étude a identifié plusieurs facteurs prédictifs d'une consultation non appropriée. Des actions sont à entreprendre pour promouvoir le bon usage du service des urgences. D'autres études auront à préciser les spécificités régionales et hospitalières.

Boisguerin, B. (2019). "Urgences : plus du quart des passages concernent les enfants de moins de 15 ans." Etudes Et Résultats (1128)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er1128.pdf

Les enfants de moins de 15 ans représentent 27 % de l'ensemble des passages aux urgences d'après la dernière enquête nationale sur les structures d'urgences hospitalières de la DREES réalisée en 2013. Le taux de recours aux urgences des enfants est beaucoup plus élevé que celui des autres groupes d'âge, à l'exception des 85 ans ou plus. La prise en charge des enfants se différencie de celle des patients âgés de 15 à 74 ans : elle concerne davantage la traumatologie et comporte moins d'examens complémentaires. La durée de passage des enfants aux urgences est ainsi plus courte, même en cas d'hospitalisation. La prise en charge des nourrissons de moins de 6 mois commence plus rapidement que celle des autres enfants, en raison de leur plus grande vulnérabilité. Ils sont plus souvent soumis à des analyses biologiques que les enfants plus âgés. Un quart des nourrissons seront hospitalisés à la suite de leur passage aux urgences. Dans les points d'accueil pédiatriques, la proportion d'enfants en bas âge est plus importante. Davantage pré-orientés vers les urgences pédiatriques par un médecin, ils y sont plus rapidement évalués et leur passage comporte moins d'examens complémentaires que dans les autres services d'urgence.

Boisguerin, B. et Mauro, L. (2017). "Les personnes âgées aux Urgences : une patientèle au profil particulier." Etudes Et Résultats (Drees) (1007)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er1007.pdf

[BDSP. Notice produite par MIN-SANTE 89BR0xoC. Diffusion soumise à autorisation]. Parmi les personnes accueillies aux urgences, les patients âgés constituent un groupe spécifique mobilisant les équipes d'urgence de façon particulière. Leurs conditions de vie et les affections liées à l'âge entraînent une fragilité supplémentaire chez ces patients. Leur prise en charge comporte un nombre d'actes plus élevé, une hospitalisation plus fréquente en unité d'hospitalisation de courte durée (UHCD), et se caractérise par une durée de passage plus longue que celle des patients plus jeunes.

Boisguerin, B. et Mauro, L. (2017). "Les personnes âgées aux urgences : une santé plus fragile nécessitant une prise en charge plus longue." Etudes Et Résultats (Drees) (1008)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er1008.pdf

[BDSP. Notice produite par MIN-SANTE R0xrq7jF. Diffusion soumise à autorisation]. Le temps de passage aux urgences est plus long pour les personnes âgées : sa durée médiane est de 4 heures pour les patients âgés de 75 ans ou plus, contre 2 heures et 10 minutes pour les 15-74 ans, en excluant les patients ayant séjourné en unité d'hospitalisation de courte durée. En prenant en compte ces derniers, la durée médiane s'allonge, de façon plus marquée pour les patients âgés. Elle est de 4 heures et 30 minutes, contre 2 heures et 20 minutes pour les patients plus jeunes.

Boisguerin, B. et Valdelievre, H. (2014). "Urgences : la moitié des patients restent moins de deux heures, hormis ceux maintenus en observation." Etudes Et Résultats (Drees) (889)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er889.pdf

[BDSP. Notice produite par MIN-SANTE A98R0xCl. Diffusion soumise à autorisation]. La prise en charge aux urgences dure moins de deux heures pour la moitié des patients si l'on exclut ceux ayant séjourné en unité d'hospitalisation de courte durée (UHCD). Dans 60% des cas, la venue dans un service d'urgences résulte de l'initiative du patient ou du conseil d'un proche. Deux patients sur trois viennent de leur domicile et sont arrivés majoritairement par leurs propres moyens. Ils sont moins souvent transportés par les sapeurs-pompiers ou par une ambulance. Le recours aux urgences est plus élevé pour les nourrissons et les personnes âgées de 75 ans ou plus et les motifs de recours sont aussi plus variés que pour les autres classes d'âges. Les lésions traumatiques constituent toujours la principale cause de venue aux urgences (36% des patients) et sont à l'origine de 7 passages sur 10 pour les 10-14 ans. Après un passage aux urgences, les 3/4 des patients rentrent chez eux et 20% sont hospitalisés.

Carrasco, V. (2006). "L'activité des services d'urgences en 2004 : une stabilisation du nombre de passages." Etudes Et Résultats (524)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er524.pdf

[BDSP. Notice produite par MIN-SANTE 4DKabR0x. Diffusion soumise à autorisation]. Les unités d'accueil et de traitement des urgences ont enregistré 14 millions de passages en 2004, après une forte progression depuis la fin des années 80. Toutefois, l'activité des services d'urgences continue à augmenter dans le secteur privé hors dotation globale (+13 % en 2004), des créations de services étant intervenues en 2003 et 2004. En moyenne, les unités d'urgences reçoivent 23 000 passages par an. Les grandes unités sont nettement plus nombreuses en Ile-de-France. Les hospitalisations après urgences concernent un patient sur cinq en 2004. En 2004, le renforcement en personnels se poursuit, plus marqué dans le secteur public que dans le secteur privé.

Carrasco, V. et Baubeau, D. (2003). "Les usagers des urgences. Premiers résultats d'une enquête nationale." Etudes Et Résultats (212)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er212.pdf

Ce document propose les premiers résultats d'une enquête nationale sur les urgences réalisée en janvier 2002. Ces premières informations sont relatives aux différentes

populations fréquentant les urgences, à leurs modes d'accès, aux motifs pour lesquelles elles consultent et aux soins qu'elles y ont reçus.

Cash, E., Cash, R. et Ducasse, J.-L. (2013). "Enquête qualitative préalable à la définition d'une enquête nationale sur les urgences hospitalières." Série Etudes Et Recherche - Document De Travail (Drees) (125)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/serieetud125.pdf

La DREES réalisera mi-2013 une enquête sur les structures des urgences hospitalières. Une première enquête avait été conduite en 2002 et avait apporté, pour la première fois, un descriptif démographique et médical des patients pris en charge dans ces structures. Depuis 2002, de nombreux changements sont intervenus tant au niveau législatif qu'au niveau médical ou des systèmes d'informations. Il a donc semblé opportun de réaliser, préalablement à la collecte de cette enquête quantitative, de faire un état des lieux qualitatif de l'organisation de la prise en charge dans les structures d'urgence et des difficultés rencontrées. Cet état des lieux a été confié par la DREES à des consultants qui ont mené une recherche bibliographique exhaustive sur les données françaises publiées ces 10 dernières années, une étude qualitative par entretiens auprès des acteurs institutionnels et analysé 5 territoires aux caractéristiques contrastées *via* une approche monographique. Le présent document recense l'ensemble des éléments d'information recueillis lors de ces démarches et dresse la synthèse des problématiques principales rencontrées dans les structures d'urgences hospitalières en 2012. C'est sur la base de ces enseignements que la DREES a défini les objectifs et les modalités de collecte de la future enquête.

Cash, E., Dupilet, C., Richard, T., et al. (2015). "Enquête qualitative préalable à la mise en place d'un dispositif statistique sur la mesure des délais d'attente dans l'accès aux soins." Série Etudes Et Recherches - Document De Travail (Drees) (133)

[BDSP. Notice produite par MIN-SANTE nR0xIArn. Diffusion soumise à autorisation]. La problématique des délais d'accès aux soins ne met pas la France en mauvaise position dans les comparaisons internationales. Cette enquête montre qu'en dehors des cas urgents, dont la prise en charge est toujours assurée, il existe des délais parfois importants dans certains territoires déficitaires en professionnels de santé, concernant principalement l'ophtalmologie, la chirurgie dentaire, la psychiatrie, la cardiologie, l'endocrinologie et la gynécologie.

Cnamts (2003). "Les Français face aux urgences : attitudes et attentes." Point De Conjoncture - La Statistique Mensuelle En Date Des Soins (16-17) : 25-33
https://www.ameli.fr/fileadmin/user_upload/documents/Point_conjoncture_16_17.pdf

A la demande de la Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (CNAMTS), le Centre de Recherche pour l'Etude et l'Observation des Conditions de vie (CREDOC) a inséré dans son enquête sur les " Conditions de vie et aspirations des français " des questions sur les modes de recours aux urgences. Le texte qui suit reprend pour l'essentiel les analyses du CREDOC à partir des réponses qui ont été faites.

Collet, M. et Gouyon, M. (2008). "Recours urgents et non programmés à la médecine de ville : satisfaction des patients et suites éventuelles." Etudes Et Résultats (Drees) (625)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er625.pdf

[BDSP. Notice produite par MIN-SANTE A8R0xjBA. Diffusion soumise à autorisation]. En prenant en charge une part considérable des recours urgents ou non programmés, les généralistes de ville répondent à une demande spécifique de soins. L'enquête, interrogeant à la fois le médecin et son patient, permet de dégager les raisons subjectives et objectives de consulter, le contenu de la séance, mais également les suites du recours. Après consultation, 94% des patients obtiennent une prescription de médicaments ou d'examens généralement respectée. Pour un recours sur dix, le médecin estime que son patient aurait pu différer sa consultation.

Colombier, G. (2007). La prise en charge des urgences médicales. Rapport d'information de l'Assemblée Nationale ; 3672. Paris Assemblée Nationale
http://www.assemblee-nationale.fr/12/pdf/rap-info/i3672.pdf

La démarche de la mission a consisté à étudier notre système de prise en charge des urgences médicales à chacun de ses trois niveaux distincts, solidaires et interdépendants : en amont des urgences, avec le dispositif de permanence des soins et les structures pré-hospitalières de prise en charge des urgences - services d'aide médicale urgente (SAMU), service mobile d'urgence et de réanimation (SMUR) et services départementaux d'incendie et de secours (SDIS) ; au sein même des structures des urgences ; en aval de ces structures, que ce soit au sein des services hospitaliers de soins aigus, dans des établissements médico-sociaux ou au domicile du patient. Le rapport est organisé suivant cette stratégie d'investigation et met un accent particulier sur l'intérêt des maisons médicales de garde qui semblent être une solution intéressante au problème de la permanence des soins en amont des urgences et sur la prise en charge des personnes âgées qui furent les premières victimes de la canicule de 2003 et qui représentent une part importante des patients accueillis aux urgences. Il insiste également sur la nécessaire clarification de la filière de soins, sur l'information du public et sur l'importance des réseaux de soins afin d'assurer une meilleure complémentarité des différents acteurs au service du patient et de la continuité de sa prise en charge. C'est précisément parce que cette complémentarité n'est pas encore suffisante que les patients, en manque de repères, se dirigent - ou sont dirigés - parfois abusivement aux urgences et y stagnent, faute d'une bonne articulation avec les autres services hospitaliers ou les autres établissements d'hébergement.

Coppoletta, R. et Le Palud, V. (2014). "Qualité et accessibilité des soins de santé : qu'en pensent les Français ?" Etudes Et Résultats (Drees) (866) : 6
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er866.pdf

[BDSP. Notice produite par MIN-SANTE 7R0xJ98G. Diffusion soumise à autorisation]. Selon le baromètre d'opinion de la DREES, les Français sont plutôt satisfaits de la qualité générale des soins de santé. Avis contrasté cependant selon les types de soins : en 2013, environ 80% d'entre eux ont une bonne opinion de la qualité des soins chez les dentistes et les médecins, ce taux est de 65% à l'hôpital public (hors urgence), 60% en clinique privée et 55% pour les urgences hospitalières. Ces résultats dépendent aussi de la région d'habitation, les habitants du Bassin parisien et de l'Est de la France étant plus critiques. Pour la première fois en 2012 et 2013, les Français considèrent les inégalités d'accès aux soins comme les moins acceptables.

Drees (2015). "Résultats de l'enquête nationale auprès des structures des urgences hospitalières." Dossiers Solidarité Et Santé (Drees) (63)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/dss63.pdf

[BDSP. Notice produite par MIN-SANTE Dp79R0xs. Diffusion soumise à autorisation]. Alors qu'on observe une hausse continue de la fréquentation des services d'urgence dans les établissements de santé, les informations disponibles en routine fournissent peu d'éléments sur les motifs de recours, les modalités de prises en charge selon les pathologies, les difficultés rencontrées ou encore la diversité des organisations et de fonctionnement des structures. La Direction de la recherche, des études, de l'évaluation et des statistiques (Drees) a réalisé une enquête un jour donné (le 11/06/2013) auprès des 736 points d'accueil d'urgences présents sur le territoire français. Le colloque de novembre 2014 a permis de présenter les premiers résultats issus de l'exploitation de cette enquête autour de quatre sessions thématiques sur la méthodologie de l'enquête, l'organisation puis la patientèle des services d'urgences et enfin la place des urgences dans l'offre de soins de premier recours.

Duval, J. J. et Saint-Paul, B. (2008). "Urgences : que pensent nos patients de l'"offre de soins" actuelle ? Une enquête d'opinion auprès de patients de la région lyonnaise." Médecine : Revue De L'unaformec 4(7) : 327-321

L'hôpital et notamment le service d'accueil des urgences (SAU) deviennent un recours de plus en plus fréquent pour les patients souhaitant accéder aux soins en dehors des heures dites ouvrables des cabinets médicaux. Cette surcharge de travail peut entraîner des difficultés à la prise en charge optimale des patients en urgence vitale. Objectif : Savoir si les patients différencient bien l'urgence vitale des situations relevant d'une consultation sans notion d'urgence, et s'ils envisageraient dans ce dernier cas d'autres solutions que l'appel systématique au SAU. Méthode : enquête d'opinion auprès de 1 017 patients dans 5 maisons médicales de garde (Lyon et Belleville/Saône) et 4 cabinets médicaux libéraux. Résultats : Les personnes qui ont répondu à l'enquête se disaient capables d'évaluer correctement le degré d'urgence de leur pathologie. Elles étaient majoritairement favorables à la création d'un numéro dédié aux consultations non urgentes et dans ce cas à un recours à des maisons médicales de garde. Discussion : Malgré toutes les limites inhérentes à ce genre d'enquête d'opinion, les patients sont favorables à des solutions alternatives au recours systématique au SAU dans le cadre de la permanence des soins pour les demandes de consultations « non urgentes ». Elles reposent d'une part sur une permanence téléphonique de qualité, d'autre part sur des « lieux » de regroupement des moyens médicaux. Conclusion : Il reste à développer par bassins de population ces solutions alternatives pour assurer les urgences ressenties par les patients, les orienter si nécessaire vers des hôpitaux en cas de souffrance grave, et éviter des aggravations injustifiées chez des patients isolés découragés par la distance kilométrique à parcourir pour avoir une consultation.

Ferley, J. P., Hedreville, L., Da Silva, E., et al. (2002). Prise en charge des consultations pédiatriques non programmées dans l'agglomération lyonnaise : Enquête en médecine libérale et dans les structures d'hospitalisation publiques et privées. Grenoble CAREPS

Le projet de constitution du réseau ville hôpital Courlygones pour la prise en charge des urgences pédiatriques dans l'agglomération lyonnaise répond au constat (non spécifique à Lyon) d'une augmentation de la demande, couplée à certains dysfonctionnements dans la prise en charge se manifestant par un recours de plus en plus fréquent aux soins non programmés, un engorgement des services d'accueil des urgences et un certain désengagement de la médecine libérale en matière de garde. A partir de ce constat, les pédiatres de l'Association pour la Journée de l'Urgence Pédiatrique (JUP) ont initié le projet Courlygones, en partenariat avec les Hospices Civils de Lyon (HCL) et l'Union Professionnelle

des Médecins Libéraux de Rhône-Alpes. Les promoteurs de ce projet ont souhaité étayer leur réflexion par une enquête transversale "un jour donné" dont la réalisation a été confiée au CAREPS. Cette enquête a reposé sur un relevé des consultations non programmées (CNP), c'est-à-dire non prévues au moins 24 heures à l'avance pour des enfants de moins de 18 ans dans l'ensemble des filières de soins de l'agglomération lyonnaise : généralistes et pédiatres libéraux (activité normale et gardes), sites d'accueil des urgences des HCL, cliniques privées.

Franchet, F. (2004). Étude des déterminants conduisant les patients qui ne relèvent pas de l'urgence médico-vitale à se présenter dans un service d'urgence public ou privé plutôt que de faire appel à la médecine de ville. Rapport final
http://www.orumip.fr/docs/CNAMTSrapport.pdf

[BDSP. Notice produite par ORSMIP lrplR0xA. Diffusion soumise à autorisation]. Les résultats de cette étude montrent que quatre urgences non vitales sur dix ont été adressées aux urgences par un médecin. Elle souligne l'importance du conseil téléphonique dans l'orientation du patient vers les services d'urgence. Du point de vue des médecins de ville, l'attitude la plus courante après un appel est de demander au patient de venir au cabinet. Cette attitude est très homogène quelle que soit la zone d'exercice : urbaine, périurbaine ou rurale.

Gentile, S., Amadei, E., Bouvenot, J., et al. (2004). "Attitudes et comportement des usagers face à une urgence réelle ou ressentie." Sante Publique 16(1) : 63-74.

[BDSP. Notice produite par ENSP R0xh3tTa. Diffusion soumise à autorisation]. Objectifs : effectuer une enquête d'opinion auprès des usagers, hors du contexte de l'urgence et en prenant en compte les recours aux soins habituels, caractériser les populations qui ont eu recours à la demande de soins d'urgence et éclairer les paramètres qui influencent cette prise de décision. Méthodologie : enquête transversale descriptive auprès d'usagers dans les centres CPAM de la zone d'attraction de l'hôpital nord de Marseille, un jour tiré au sort (7 jours au total). Résultats : l'exploitation de 253 questionnaires remplis montrent que la population est plutôt féminine, jeune, défavorisée mais non exclue du système de soins.

Gentile, S., Durand, A. C., Vignally, P., et al. (2009). "Les patients "non urgents" se présentant dans les services d'urgence sont-ils favorables à une réorientation vers une structure de soins alternative ?" Revue D'épidémiologie Et De Sante Publique 57(1)

[BDSP. Notice produite par ORSRA kR0xm8GC. Diffusion soumise à autorisation]. Les services d'urgence (SU) connaissent un problème d'engorgement dû à la part croissante de patients dits "non urgents". Pour pallier ce problème, des dispositifs, comme les Maisons médicales de garde (MMG), ont été mis en place. L'objectif de ce travail est d'évaluer la disposition des patients "non urgents" à être réorientés vers ces dispositifs dès leur entrée au SU. Une étude transversale d'une semaine a été menée dans le SU adulte de l'hôpital de La Conception (Marseille). Les patients jugés "non urgents" par l'infirmière d'accueil et d'orientation (IAO) ont été, dès leur entrée, interrogés sur leur mode de soins habituels, les motifs et le parcours de soins avant le SU, le niveau d'urgence ressenti et leur disposition vis-à-vis d'une éventuelle réorientation, enfin les actes réalisés et le mode de sortie. Résultats : Parmi les 245 patients reçus, 110 ont été jugés "non urgents" par l'IAO et 85 ont pu être interrogés. Dans 76,4% des cas, le patient a décidé seul de son recours au SU, mais un tiers avait auparavant cherché à contacter un médecin. Les principaux motifs de consultation sont la douleur (55,3%), l'accès au plateau technique (37,6%) et la difficulté à obtenir un rendez-

vous en ville (22,3%). Le niveau moyen d'urgence ressenti est de 10,6 sur une échelle de zéro à vingt. La moitié des motifs sont traumatologiques. Un tiers des patients a eu un examen complémentaire, six un acte thérapeutique et aucun n'a été hospitalisé. Plus des deux tiers des patients accepteraient d'être réorientés à leur arrivée au SU. Les deux principaux facteurs liés à cette décision sont l'activité professionnelle (odds-ratio [OR]=4,5 ; intervalle de confiance [IC] 95%=1,6-12,9) et le niveau d'urgence ressenti (OR=0,88 ; IC 95%=0,8-0,9). Parmi les consultants refusant la réorientation (31,8%), près de 41% d'entre eux seraient prêts à payer un supplément pour rester au SU. Conclusion : Des structures comme les MMG, adossées aux SU, semblent constituer une alternative pertinente pour les consultants "non urgents". Le succès des réorientations pourrait cependant être conditionné par les horaires d'ouverture de ces structures et la pratique de certains actes techniques.

Gouyon, M. (2006). "Les recours aux médecins urgentistes de ville." Etudes Et Résultats (480)

[BDSP. Notice produite par ENSP A56R0xO9. Diffusion soumise à autorisation]. Selon l'enquête menée par la Drees au cours du mois d'octobre 2004, les visites des médecins exerçant au sein d'une association d'urgentistes de ville, telle que SOS Médecins ou Urgences Médicales de Paris, représentent 5 % des recours urgents ou non programmés à la médecine générale. Les associations d'urgentistes sont dans un tiers des cas sollicitées pour des enfants de moins de 13 ans, souffrant généralement de troubles somatiques. 92 % des déplacements d'urgentistes sont motivés par des affections aiguës, l'état clinique du patient étant d'autant plus critique que celui-ci est âgé. Si la durée moyenne d'une visite est de 17 minutes pour un patient de 13 ans, elle atteint 24 minutes pour une personne de 70 ans, et 40 minutes lorsque le pronostic vital est engagé. Lors d'un recours urgent, les urgentistes de ville dispensent moins de médicaments que leurs confrères généralistes exerçant en cabinet. En revanche, ils prodiguent plus de conseils de prévention et d'hygiène de vie et pratiquent davantage de gestes thérapeutiques. Trois recours sur cinq auprès d'un urgentiste de ville se concluent par une orientation du patient vers un médecin généraliste ou spécialiste, et près d'un sur dix par une hospitalisation.

Gouyon, M. (2006). "Une typologie des recours urgents ou non programmés à la médecine de ville." Dossiers Solidarité Et Santé (Drees) (1) : 61-67.
https://drees.solidarites-sante.gouv.fr/IMG/pdf/dossier200601.pdf

[BDSP. Notice produite par MIN-SANTE Q9R0xqTs. Diffusion soumise à autorisation]. En 2004, les recours urgents ou non programmés représentaient, en France métropolitaine, 12% de l'activité des médecins généralistes exerçant en cabinet ou dans une association d'urgentistes. A partir de cette enquête réalisée par la DREES, sept grands types de recours urgents à la médecine générale ont été mis en évidence. Ils reposent à la fois sur les motifs des séances, leur contenu et leur issue et sur les caractéristiques des patients et des médecins.

Gouyon, M. et Labarthe, G. (2006). "Les recours urgents ou non programmés en médecine générale. Premiers résultats." Etudes Et Résultats (471)

[BDSP. Notice produite par ENSP sMR0xEXy. Diffusion soumise à autorisation]. Selon l'enquête menée par la Drees en octobre 2004 auprès de 1400 médecins de ville, les recours urgents ou non programmés constituent 12% de l'activité totale des médecins libéraux. Ils concernent particulièrement des enfants de moins de 13 ans (22 % des patients reçus dans ce cadre) et des adultes de 25 à 45 ans (26%).

Ladner, J., Bailly, L., Pitrou, I., et al. (2008). "Les patients auto-référés dans les services hospitaliers d'urgences : motifs de recours aux urgences et comportements de consommation de soins." Pratiques Et Organisation Des Soins (1) : 33-42.
http://www.ameli.fr/fileadmin/user_upload/documents/Motifs_de_recours_auto-referes_aux_urgences.pdf

[BDSP. Notice produite par CNAMTS 8IprR0xH. Diffusion soumise à autorisation]. L'objectif était d'étudier les comportements de consommation de soins et les modalités de prise en charge chez des patients auto-référés, en fonction de leurs motifs de recours. Entre juillet 2003 et mars 2004, une étude de cohorte prospective a été conduite dans quatre services d'urgences en Haute-Normandie. Le recours aux soins dans les six mois précédents et les motifs détaillés de recours aux urgences, ont été classés en quatre groupes : plus commode de venir directement aux urgences (G1), médecin traitant non disponible (G2), problème de santé persistant (G3), avis non demandé (G4). Le groupe G1 se distingue des trois autres groupes : patients jeunes, actifs professionnellement, ayant tendance à consulter facilement les services d'urgences. Il y a aujourd'hui une demande des usagers pour une prise en charge rapide et efficace.

Moisy, M. (2015). "Le recours aux soins des sans-domicile : neuf sur dix ont consulté un médecin en 2012." Etudes Et Résultats (Drees) (933)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er-recours_aux_soins_sd-v4-0409.pdf

[BDSP. Notice produite par MIN-SANTE 77R0xDk7. Diffusion soumise à autorisation]. En 2012, près de neuf personnes sans domicile sur dix ont consulté un médecin au cours des douze derniers mois. Les femmes et les personnes de moins de 60 ans se rendent plus fréquemment chez le généraliste ou le spécialiste. 37 % des sans domicile ne sont pas allés chez le dentiste au cours des deux dernières années et 7 % ne s'y sont jamais rendus. Un sans domicile sur dix déclare ne bénéficier d'aucune couverture maladie et un sur quatre d'aucune complémentaire santé. Ce constat masque des situations contrastées et peut expliquer un recours fréquent aux soins hospitaliers : 20 % des dernières consultations chez un médecin se sont déroulées à l'hôpital. Par ailleurs, un tiers des sans domicile précisent avoir été hospitalisés au moins une fois dans l'année écoulée et citent la maladie comme principal motif d'hospitalisation. 72 % des enquêtés sont passés par les urgences lors de leur dernière hospitalisation.

Or, Z. et Penneau, A. (2017). Analyse des déterminants territoriaux du recours aux urgences non suivi d'une hospitalisation. Document de travail (Irdes) ; 72. Paris Irdes
http://www.irdes.fr/recherche/documents-de-travail/072-analyse-des-determinants-territoriaux-du-recours-aux-urgences-non-suivi-d-une-hospitalisation.pdf

Les services d'urgence sont essentiels au système de santé afin de traiter rapidement les situations d'urgences médicales. Ils sont cependant souvent utilisés pour des prises en charge non urgentes pouvant être réalisées dans le secteur ambulatoire. La rapide augmentation du volume de passages aux urgences, particulièrement chez les sujets âgés, est une source de pression pour les hôpitaux et le système de soins. Cette étude a pour objectif d'identifier les déterminants territoriaux du recours aux urgences non suivi d'hospitalisation des personnes âgées de 65 ans et plus.

Or, Z. et Penneau, A. (2018). "A Multilevel Analysis of the determinants of emergency care visits by the elderly in France." Health Policy 122(8) : 908-914

BACKGROUND : Rising numbers of visits to emergency departments (EDs), especially amongst the elderly, is a source of pressure on hospitals and on the healthcare system. This study aims to establish the determinants of ED visits in France at a territorial level with a focus on the impact of ambulatory care organisation on ED visits by older adults aged 65 years and over. METHODS : We use multilevel regressions to analyse how the organisation of healthcare provision at municipal and wider 'department' levels impacts ED utilisation by the elderly while controlling for the local demographic, socioeconomic and health context of the area in which patients live. RESULTS : ED visits vary significantly by health context and economic level of municipalities. Controlling for demand-side factors, ED rates by the elderly are lower in areas where accessibility to primary care is high, measured as availability of primary care professionals, out-of-hours care and home visits in an area. Proximity (distance) and size of ED are drivers of ED use. CONCLUSION : High rates of ED visits are partly linked to inadequate accessibility of health services provided in ambulatory settings. Redesigning ambulatory care at local level, in particular by improving accessibility and continuity of primary and social care services for older adults could reduce ED visits and, therefore, improve the efficient use of available healthcare resources.

Peneff, J. (2000). Les malades des urgences : une forme de consommation médicale, Paris : Métailié

Les malades des urgences, une nouvelle forme de consommation médicale ou un nouveau type de rapport entre les médecins et leurs clients ? Quelles sont les fonctions des urgences ? Pourquoi ont-elles pris la place de la médecine généraliste (ou spécialiste) de ville auprès de certaines populations urbaines qui les préfèrent à la consultation de cabinet ou à la visite du médecin de famille ? Beaucoup de jeunes, d'étrangers et de familles aux revenus modestes les utilisent de préférence à d'autres modes de rencontre avec les médecins. En revanche, d'autres populations les évitent. Les classes supérieures ont leurs propres réseaux de consultation en urgence et de traitement et se détournent de ces services, sauf accident grave. Des catégories d'exclus et de démunis, même avec une couverture sociale ou assurés de la gratuité, privilégient la médecine caritative bénévole. Quels sont les mobiles des utilisateurs : avantages financiers, accessibilité et commodité d'horaires, relation médicale rapide, sans suivi, dans une collectivité en majorité féminine (évitant le colloque singulier avec le médecin) ? Si les urgences deviennent une médecine ordinaire, populaire, risquent-elles d'être assimilées à une médecine du pauvre, comme dans les hôpitaux publics américains tel celui du feuilleton Urgences, modèle de bonne conscience et de démagogie dans le principe d'égalité des soins. Y a-t-il un risque, en France, d'une transgression dans le traitement démocratique des malades à l'hôpital ? Ce livre ne répond pas à toutes ces questions mais il ne les élude pas, notamment la question du remboursement public d'activités libérales dont on cherche à savoir s'il aggrave ou compense les inégalités sociales. En clair, un transfert des charges collectives et des cotisations au profit des classes aisées est-il réalisé par le mode de remboursement de la Sécurité sociale et par l'organisation médicale en deux secteurs, public et privé ? En étudiant un niveau d'accès aux soins, une nouvelle forme de consommation médicale, cet ouvrage pose des problèmes politiques, sans détour, grâce à une enquête et une observation de la population qui se presse aux portes des urgences de trois hôpitaux parisiens : Beaujon, Ambroise-Paré, La Pitié-Salpétrière (4e de couverture).

Praznoczy-Pepin, C. (2007). Les recours urgents ou non programmés en médecine générale en Ile-de-France. Urgences en médecine générale. Paris ORSIF
https://www.ors-idf.org/fileadmin/DataStorageKit/ORS/Etudes/2007/Etude2007_7/2007_recoursSoins_urgences_1_.pdf

Basée sur une enquête réalisée par la Direction de la recherche ? des études et de l'évaluation et des statistiques (Drees) dans toutes les régions de France métropolitaine, en octobre 2004, cette étude analyse les recours urgents ou non programmés en médecine générale en Ile-de-France. Les médecins concernés sont les libéraux exerçant ou non au sein d'une association D'urgentistes. L'analyse porte sur les caractéristiques socio-démographiques des patients, les motifs de recours, la durée des séances, les prescriptions d'actes et les orientations à la suite des visites et consultations.

Ricroch, L. et Vuagnat, A. (2017). "Les hospitalisations après passage aux urgences moins nombreuses dans le secteur privé." Etudes Et Résultats (Drees) (997)
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er997.pdf

[BDSP. Notice produite par MIN-SANTE F9R0xnDA. Diffusion soumise à autorisation]. Mardi 11 juin 2013, un quart des passages aux urgences de patients âgés de 15 ans et plus se poursuivent par une hospitalisation dans un autre service. La décision d'hospitalisation se fonde principalement sur l'état de santé des patients : le motif de recours aux urgences, la gravité associée au diagnostic, la présence de pathologies au long cours, l'avancée en âge. D'autres facteurs, comme l'éloignement important des urgences, sont associés à une fréquence plus élevée de décision d'hospitalisation : un tiers des patients pris en charge à plus de 20 km de leur domicile sont hospitalisés. Le taux d'hospitalisation depuis les urgences apparaît moins élevé dans les établissements de santé privés à but lucratif (15 %) que dans les établissements de santé publics (26 %).

Sannino, N. et Picon, E. (2016). Etude des parcours de soins des personnes en situation de précarité : spécificité en rapport avec l'environnement local. Paris Ministère chargé de la santé
http://www.itinere-conseil.com/wp-content/uploads/2019/01/dgos-rapport-etude-des-parcours-de-soins.pdf

Malgré la connaissance descriptive de nombreux déterminants de l'accès aux soins des publics précaires, la réalité du caractère complexe de leur prise en charge (retard dans l'accès aux soins, ruptures de suivi, modes d'entrée spécifiques en particulier par les offreurs de soins les plus visibles comme les urgences de l'hôpital) et l'explicitation de cette complexité (imbrication de difficultés, multi pathologies) demeurent insuffisantes pour la Direction générale de l'offre de soins pour disposer d'une vision d'ensemble et proposer les adaptations structurelles en corollaire, ainsi que des modifications dans l'état d'esprit et les pratiques professionnelles. Afin de mieux définir une politique d'organisation territoriale des soins , adaptée et adossée à des facteurs clés de réussite, la DGOS a donc souhaité disposer d'une étude visant à reconstituer les parcours d'un échantillon de personnes en situation de précarité et objectiver la réalité du caractère complexe de la prise en charge en identifiant, le cas échéant, les différents éléments de blocage, par types. In fine, il s'agit d'analyser la part de l'organisation dans les difficultés d'accès aux soins des publics « précaires » et de proposer des améliorations relatives à l'organisation de l'offre de soins, en termes d'information, de modalités de prise en charge et de suivi, de coordination des acteurs afin que les populations en situation de précarité bénéficient du juste enchaînement et au bon moment des différentes compétences professionnelles liées directement ou indirectement

aux soins. Les résultats sont présentés dans ce rapport réalisé par deux sociétés de consultants.

ÉTUDES INTERNATIONALES

Coster, J. E., Turner, J. K., Bradbury, D., et al. (2017). "Why Do People Choose Emergency and Urgent Care Services? A Rapid Review Utilizing a Systematic Literature Search and Narrative Synthesis." BMJ Open 24(9) : 1137-1149.

OBJECTIVES: Rising demand for emergency and urgent care services is well documented, as are the consequences, for example, emergency department (ED) crowding, increased costs, pressure on services, and waiting times. Multiple factors have been suggested to explain why demand is increasing, including an aging population, rising number of people with multiple chronic conditions, and behavioral changes relating to how people choose to access health services. The aim of this systematic mapping review was to bring together published research from urgent and emergency care settings to identify drivers that underpin patient decisions to access urgent and emergency care. METHODS: Systematic searches were conducted across Medline (via Ovid SP), EMBASE (via Ovid), The Cochrane Library (via Wiley Online Library), Web of Science (via the Web of Knowledge), and the Cumulative Index to Nursing and Allied Health Literature (CINAHL; via EBSCOhost). Peer-reviewed studies written in English that reported reasons for accessing or choosing emergency or urgent care services and were published between 1995 and 2016 were included. Data were extracted and reasons for choosing emergency and urgent care were identified and mapped. Thematic analysis was used to identify themes and findings were reported qualitatively using framework-based narrative synthesis. RESULTS: Thirty-eight studies were identified that met the inclusion criteria. Most studies were set in the United Kingdom (39.4%) or the United States (34.2%) and reported results relating to ED (68.4%). Thirty-nine percent of studies utilized qualitative or mixed research designs. Our thematic analysis identified six broad themes that summarized reasons why patients chose to access ED or urgent care. These were access to and confidence in primary care; perceived urgency, anxiety, and the value of reassurance from emergency-based services; views of family, friends, or healthcare professionals; convenience (location, not having to make appointment, and opening hours); individual patient factors (e.g., cost); and perceived need for emergency medical services or hospital care, treatment, or investigations. CONCLUSIONS: We identified six distinct reasons explaining why patients choose to access emergency and urgent care services: limited access to or confidence in primary care; patient perceived urgency; convenience; views of family, friends, or other health professionals; and a belief that their condition required the resources and facilities offered by a particular healthcare provider. There is a need to examine demand from a whole system perspective to gain better understanding of demand for different parts of the emergency and urgent care system and the characteristics of patients within each sector.

(2016). "Correction: Describing team development within a novel GP-led urgent care centre model: a qualitative study." BMJ Open 6(7) : e010224corr010221.

Abd El-Fatah, S. (2017). "Unmet healthcare needs for older people attending the outpatients' clinics of a university hospital in Cairo, Egypt: a qualitative study." J Egypt Public Health Assoc 92(4) : 220-227.

BACKGROUND: Egypt is experiencing significant changes in age structure mostly among the older population, which is expected to quadruple over the period 2010-2050. There is no easy, quick-fix recipe for elders' health needs assessment. Qualitative methods are required to explain what is already known. This study aimed to assess the unmet healthcare needs of the elders attending the outpatients' clinics of the Cairo University Hospital. MATERIALS AND METHODS: A qualitative design with a thematic content analysis of semistructured interviews was used to assess the unmet healthcare needs of elders above 60 years of age, attending the outpatients' clinics of Cairo University Hospital. RESULTS: The most bothersome complaints were the overcrowding and abnormally long waiting times followed by the falsely

claimed free of charge governmental services. Besides, the lack of outpatient long-term management was coupled with the fact that some of the needed health services were unavailable, not easily accessible, and insufficient. Moreover, worthless dealing was the most prominent theme in patients' opinions regarding bad healthcare providers, starting from verbal or nonverbal aggression and prejudice to inadequate information provision for the improvement of elders' health. CONCLUSION: Problems facing older patients in the outpatients' clinics included lack of follow-up services, fractional treatment by the health providers, and absence of internal complaints mechanism. Their suggestions for improvement focused on improving the communication skills of healthcare providers and establishing continuity of the care system. Inevitable improvements in the clinics' services include: establishment of a geriatric clinic with a multidisciplinary clinical team in addition to enhancing communication and health education with the elders, negotiating to arrive at the best therapeutic options, and fostering motivation and skills needed for self-care.

Ablard, S. et Kuczawski, M. (2020). "What does the ideal urgent and emergency care system look like? A qualitative study of service user perspectives." Emerg Med J 37(4):200-205

BACKGROUND: Policies aimed at diverting care from EDs to alternative services have not been successful in reducing ED attendances and have contributed to confusion for service users when making care-seeking decisions. It is important that service users are at the heart of decision making to ensure new services meet the needs of those who will be accessing them. In this study, service users were encouraged to think freely about the desirable qualities of an ideal urgent and emergency care (UEC) system. METHODS: From September to February 2019, an open inductive methodology was used to conduct focus groups with service users who had used UK UEC services within the previous year. Service users that had contact with NHS111, ambulance service, General Practice out-of-hours, minor injuries unit, walk-in centre or ED were purposively sampled and stratified into the following groups: (1) 18-45 years; (2)>/=75 years; (3) adults with young children; (4) adults with long-term conditions. Focus groups were structured around experiences of accessing UEC services and perspectives of an 'ideal' UEC system. RESULTS: 30 service users took part in the study, across four focus groups. The ideal UEC system centred around three themes: a simplified UEC system (easier to understand and a single-point of access); more 'joined-up' UEC services and better communication between health staff and patients. CONCLUSION: Desirable qualities of an ideal UEC system from a service user perspective related to simplifying access for example, through a single point of access system where health professionals decide the appropriate service required and improving continuity of care through better integration of UEC services. Service users value reassurance and communication from health professionals about care pathways and care choices, and this helps service users feel more in control of their healthcare journey.

Agarwal, A. K., Mahoney, K., Lanza, A. L., et al. (2019). "Online Ratings of the Patient Experience: Emergency Departments Versus Urgent Care Centers." Ann Emerg Med 73(6) : 631-638.

STUDY OBJECTIVE: Individuals increasingly use online rating platforms to rate and review hospitals. We seek to describe and compare publicly available online review content and ratings of emergency departments (EDs) and urgent care centers. METHODS: We analyzed Yelp reviews of EDs and urgent care centers to identify topics most correlated with 1- and 5-star ratings. Latent Dirichlet Allocation, a method of identifying groups of co-occurring words in narrative text, was used to identify and label 25 topics across 1- and 5-star reviews of urgent care centers and EDs. Differential Language Analysis was then used to measure the

correlation of these topics with 1- and 5-star reviews for urgent care centers and EDs. RESULTS: We analyzed 100,949 Yelp reviews, 16,447 from 1,566 EDs and 84,502 from 5,601 urgent care centers. There were significantly more 5-star urgent care center reviews (n=43,487; 51%) than 5-star ED reviews (n=4,437; 27%). Themes associated with 5-star reviews among EDs and urgent care centers were similar for comfort, professionalism, facilities, pediatric care, and staff interactions. Themes associated with 1-star reviews among EDs and urgent care centers were similar for communication, telephone experience, waiting, billing, pain management, and diagnostic testing. Themes unique to 5-star ED reviews included bedside manner, care for family members, and access. Themes unique to 5-star urgent care center reviews were based on recommendation and prescription refills. Themes unique to 1-star ED reviews were service and speed of care. Themes unique to 1-star urgent care center reviews were lack of confidence and reception experience. CONCLUSION: Understanding drivers for high and low online ratings and what patients value in their ED and urgent care center experiences offers insights for health systems and providers to improve acute care delivery. Patients' perspectives may become increasingly important as they seek care in the expanding urgent care markets.

Ahmed, A. et Fincham, J. E. (2011). "Patients' view of retail clinics as a source of primary care: boon for nurse practitioners?" J Am Acad Nurse Pract 23(4) : 193-199.

PURPOSE: To estimate consumer utilities associated with major attributes of retail clinics (RCs). DATA SOURCES: A discrete choice experiment (DCE) with 383 adult residents of the metropolitan statistical areas in Georgia conducted via Random Digit Dial survey of households. The DCE had two levels each of four attributes: price ($59; $75), appointment wait time (same day; 1 day or more), care setting-provider combination (nurse practitioner [NP]-RC; physician-private office), and acute illness (urinary tract infection; influenza), resulting in 16 choice scenarios. The respondents indicated whether they would seek care under each scenario. CONCLUSIONS: Cost savings and convenience offered by RCs are attractive to urban patients, and given sufficient cost savings they are likely to seek care there. All else equal, one would require cost savings of at least $30.21 to seek care from an NP at RC rather than a physician at private office, and $83.20 to wait one day or more. IMPLICATIONS FOR PRACTICE: Appointment wait time is a major determinant of care-seeking decisions for minor illnesses. The size of the consumer utility associated with the convenience feature of RCs indicates that there is likely to be further growth and employment opportunities for NPs in these clinics.

Asgary, R. et Segar, N. (2011). "Barriers to health care access among refugee asylum seekers." J Health Care Poor Underserved 22(2) : 506-522.

OBJECTIVE: Asylum seekers have poor access to health care. Qualitative data portraying their experience is lacking. METHODS: We conducted focus groups and comprehensive interviews with 35 asylum seekers and 15 expert providers/advocacy organization representatives. Purposive sampling was used to recruit subgroups. Interviews were recorded, coded, and analyzed. RESULTS: PARTICIPANTS: 85% male, mostly from African countries. Major barriers: a) Internal, including mental illness, fatalism, mistrust, and perceived discrimination; b) Structural, including affordability, limited services, inadequate interpretation, resettlement challenges such as shelter, food, and employment insecurity; health care for urgent care only; and poor cultural competency; c) Barriers in social assimilation, including difficulty navigating a complex system and inadequate community support. CONCLUSION: Significant inter-related barriers exist at the individual, provider, and system levels. Strategies to

improve access include targeting social programs and mental health services, expanding Medicaid eligibility/enrollment, promoting community-based organizations, enforcing the use of trained medical interpreters, and improving cultural competency.

Barry, H. E. (2016). "The use of patient experience survey data by out-of-hours primary care services: a qualitative interview study." BMJ Open 25(11) : 851-859.

BACKGROUND: English National Quality Requirements mandate out-of-hours primary care services to routinely audit patient experience, but do not state how it should be done. OBJECTIVES: We explored how providers collect patient feedback data and use it to inform service provision. We also explored staff views on the utility of out-of-hours questions from the English General Practice Patient Survey (GPPS). METHODS: A qualitative study was conducted with 31 staff (comprising service managers, general practitioners and administrators) from 11 out-of-hours primary care providers in England, UK. Staff responsible for patient experience audits within their service were sampled and data collected via face-to-face semistructured interviews. RESULTS: Although most providers regularly audited their patients' experiences by using patient surveys, many participants expressed a strong preference for additional qualitative feedback. Staff provided examples of small changes to service delivery resulting from patient feedback, but service-wide changes were not instigated. Perceptions that patients lacked sufficient understanding of the urgent care system in which out-of-hours primary care services operate were common and a barrier to using feedback to enable change. Participants recognised the value of using patient experience feedback to benchmark services, but perceived weaknesses in the out-of-hours items from the GPPS led them to question the validity of using these data for benchmarking in its current form. CONCLUSIONS: The lack of clarity around how out-of-hours providers should audit patient experience hinders the utility of the National Quality Requirements. Although surveys were common, patient feedback data had only a limited role in service change. Data derived from the GPPS may be used to benchmark service providers, but refinement of the out-of-hours items is needed.

Beckett, J., Barley, J. et Ellis, C. (2015). "Patient perspectives of barriers and facilitators of treatment-seeking behaviors for stroke care." J Neurosci Nurs 47(3) : 154-159.

OBJECTIVE: Delays in seeking treatment for stroke care are associated with greater disability and reductions in stroke outcomes. The objective of this study was to qualitatively examine facilitators and barriers to urgently seeking stroke-related care. METHODS: A qualitative analytic approach was used to explore facilitators and barriers to seeking stroke care in an urgent manner. Sixty-four stroke survivors offered information related to facilitators and barriers to stroke care via a structured survey as part of a larger mixed-methods study designed to measure stroke outcomes. RESULTS: Three themes emerged related to facilitators and barriers: (a) recognition of symptoms, (b) social support, and (c) knowledge and ability to call emergency medical services as a first response. Facilitators to urgent care-seeking behaviors included classic stroke symptoms, severe symptoms, sudden symptom onset, and high perceived level of emergency. Social support and knowledge/ability to call emergency medical services also emerged as facilitators of urgent care. Barriers to urgent care-seeking behaviors included atypical symptoms, mild symptoms, gradual symptom onset, and low perceived level of emergency. CONCLUSIONS: Individuals who experience strokes face a number of facilitators and barriers to seeking urgent care for their condition. Facilitators and barriers are associated with stroke symptoms and their personal

environments. Additional study of barriers to stroke care is needed to adequately design interventions to reduce delays in seeking treatment.

Bernstein, M. T., Walker, J. R., Chhibba, T., et al. (2017). "Health Care Services in IBD: Factors Associated with Service Utilization and Preferences for Service Options for Routine and Urgent Care." Inflamm Bowel Dis 23(9) : 1461-1469.

BACKGROUND: We aimed to explore factors associated with health service utilization and preference for services, including alternatives to attending the emergency department (ED) when experiencing mild to moderate or severe symptoms. METHODS: A total of 1143 persons (46% response rate) aged 18 to 65 years in the population-based University of Manitoba IBD Research Registry participated in the survey. RESULTS: Although 61% had a gastroenterologist, when experiencing active symptoms, only 29% felt they could call their gastroenterologist for an urgent appointment, and 42% could call their gastroenterologist for telephone advice. Nine percent of the respondents visited the ED in the previous year. If having severe symptoms, 48% said that they would attend the ED. Visits to the ED were related to higher bowel symptom severity and high health anxiety. When experiencing severe symptoms, women, persons with Crohn's disease and those with high health anxiety, indicated that they would be more likely to use the ED. Considering services which could be available in the future respondents indicated that if acutely symptomatic they would be very likely or likely to use the following services: phone contact with inflammatory bowel disease nurse (77%), phone contact with a gastroenterologist (75%), and going to a walk-in gastroenterology clinic (71%). CONCLUSIONS: Persons with inflammatory bowel disease are receptive to options other than the ED when experiencing inflammatory bowel disease symptoms; however, attending the ED remains a prominent choice. Improved access to specialized care may improve timeliness of care and reduce ED attendance. Future research should include the impact of health anxiety on health care utilization.

Booker, M. J., Simmonds, R. L. et Purdy, S. (2014). "Patients who call emergency ambulances for primary care problems: a qualitative study of the decision-making process." Emerg Med J 31(6) : 448-452.

BACKGROUND: Telephone calls for emergency ambulances are rising annually, increasing the pressure on ambulance resources for clinical problems that could often be appropriately managed in primary care. OBJECTIVE: To explore and understand patient and carer decision making around calling an ambulance for primary care-appropriate health problems. METHODS: Semistructured interviews were conducted with patients and carers who had called an ambulance for a primary care-appropriate problem. Participants were identified using a purposive sampling method by a non-participating research clinician attending '999' ambulance calls. A thematic analysis of interview transcripts was undertaken. RESULTS: A superordinate theme, patient and carer anxiety in urgent-care decision making, and four subthemes were explored: perceptions of ambulance-based urgent care; contrasting perceptions of community-based urgent care; influence of previous urgent care experiences in decision making; and interpersonal factors in lay assessment and management of medical risk and subsequent decision making. CONCLUSIONS: Many calls are based on fundamental misconceptions about the types of treatment other urgent-care avenues can provide, which may be amenable to educational intervention. This is particularly relevant for patients with chronic conditions with frequent exacerbations. Callers who have care responsibilities often default to the most immediate response available, with decision making driven by a lower tolerance of perceived risk. There may be a greater role for more detailed triage in these

cases, and closer working between ambulance responses and urgent primary care, as a perceived or actual distance between these two service sectors may be influencing patient decision making on urgent care.

Brown, S., Henderson, E., Howse, J., et al. (2012). "Patient views of single number access to urgent care services." Fam Pract 29(6) : 713-718.

BACKGROUND: In October 2009, NHS County Durham and Darlington introduced a single point of access telephone number for people requiring out-of-hours health care. We evaluated users' views and experiences of the service. METHODS: We used a validated questionnaire adapted for use in telephone interviews, with open-ended questions added to allow people to express their views. Interviews were carried out with 493 people who had used the urgent care line between April and July 2010 of 1626 telephone calls made, a response rate of 30.3%. SPSS 17.0 was used to analyse the quantitative data and Framework analysis the qualitative data. RESULTS: We found that (i) regardless of age or gender people who used the call line were satisfied with the service they received, (ii) the call line advised most cases to go to an urgent care centre, (iii) people who received advice other than that expected were still satisfied with the service. Criticisms of the service related to confusion about accessing the service and which number callers should use. CONCLUSIONS: We found very high levels of satisfaction across all groups for a single point of access telephone number for urgent care. Clear information about the service, in particular that it will involve telephone triage and that access to a doctor or nurse is not immediate, may also resolve some instances of dissatisfaction. It appears that the service is effective in directing people to places where they can be dealt with appropriately.

Campbell, J. L., Asprey, A., Richards, S. H., et al. (2015). "Perceptions of healthcare professionals and managers regarding the effectiveness of GP-led walk-in centres in the UK." BMJ Qual Saf 5(8) : e008286.

OBJECTIVES: This study aimed to identify the perceptions of healthcare professionals regarding the effectiveness and the impact of a new general practitioner-led (GP-led) walk-in centre in the UK. SETTING: This qualitative study was conducted in a large city in the North of England. In the past few years, there has been particular concern about an increase in the use of emergency department (ED) services provided by the National Health Service and part of the rationale for introducing the new GP-led walk-in centres has been to stem this increase. The five institutes included in the study were EDs, a minor injuries unit, a primary care trust, a GP-led walk-in centre and GP surgeries. PARTICIPANTS: Semistructured interviews were conducted with healthcare providers at an adult ED, an ED at a children's hospital, a minor injuries unit, a GP-led walk-in centre, GPs from surrounding surgeries and GPs. RESULTS: 11 healthcare professionals and managers were interviewed. Seven key themes were identified within the data: the clinical model of the GP-led walk-in centre; public awareness of the services; appropriate use of the centre; the impact of the centre on other services; demand for healthcare services; choice and confusion and mixed views (positive and negative) of the walk-in services. There were discrepancies between the managers and healthcare professionals regarding the usefulness of the GP-led walk-in centre in the current urgent care system. CONCLUSIONS: Participants did not notice declines in the demand for EDs after the GP-led walk-in centre. Most of the healthcare professionals believed that the GP-led walk-in centre duplicated existing healthcare services. There is a need to have a better communication system between the GP-led walk-in centres and other healthcare providers to have an integrated system of urgent care delivery.

Chow, M. Y., Li, M. et Quine, S. (2012). "Client satisfaction and unmet needs assessment: evaluation of an HIV ambulatory health care facility in Sydney, Australia." Asia Pac J Public Health 24(2) : 406-414.

> A mixed-methods approach study was conducted at an ambulatory HIV health care facility in Sydney during 2007/2008. A quantitative self-administered structured questionnaire survey (phase 1) was conducted to assess client satisfaction levels, followed by qualitative semistructured interviews (phase 2) to investigate reasons for satisfaction/dissatisfaction and unmet needs. The mean overall satisfaction score of the 166 respondents in phase 1 was high (86 out of 100). Participants were most satisfied with the "knowledge" and "attitudes" of health care providers (HCP) and "maintenance of confidentiality." They were least satisfied with "waiting time before consultation." "Knowledge of HCP" and "rapport, care, and trust towards HCP" emerged as most important aspects of satisfaction. The broad range of HCP and services provided at one location was particularly appreciated. Health care service evaluation by assessing client satisfaction using mixed methods provided valuable insight into health care service quality. It can be applied to a broader range of health care services.

CIHI (2014). Sources des visites potentiellement évitables aux services d'urgence. Ottawa C.I.H.I
https://secure.cihi.ca/free_products/ED_Report_ForWeb_FR_Final.pdf

> Les services d'urgence traitent en priorité les patients qui ont des besoins urgents et qui nécessitent des soins très spécialisés. Or, les Canadiens se rendent souvent à l'urgence pour des problèmes qui pourraient être traités plus adéquatement dans un autre milieu de soins. Pour favoriser la continuité des soins et améliorer l'expérience globale de ces patients, il pourrait être bénéfique de les diriger vers un milieu approprié. Les ressources des services d'urgence pourraient alors être consacrées aux patients qui en ont vraiment besoin. La présente étude porte sur 2 groupes de patients susceptibles d'obtenir des soins plus appropriés dans des milieux autres que les services d'urgence : Les personnes qui ont visité un service d'urgence pour des problèmes médicaux mineurs et qui ont obtenu leur congé sans être hospitalisées ; Les personnes âgées vivant en établissement de soins de longue durée qui ont visité un service d'urgence pour des affections potentiellement évitables ou pour des affections jugées moins urgentes et n'ayant pas mené à une hospitalisation. Le rapport examine la fréquence et les caractéristiques de ces visites potentiellement évitables au service d'urgence et dresse un portrait détaillé des patients qui les effectuent.

Coster, J. E., Turner, J. K., Bradbury, D., et al. (2017). "Why Do People Choose Emergency and Urgent Care Services? A Rapid Review Utilizing a Systematic Literature Search and Narrative Synthesis." BMJ Open 24(9) : 1137-1149.

> OBJECTIVES: Rising demand for emergency and urgent care services is well documented, as are the consequences, for example, emergency department (ED) crowding, increased costs, pressure on services, and waiting times. Multiple factors have been suggested to explain why demand is increasing, including an aging population, rising number of people with multiple chronic conditions, and behavioral changes relating to how people choose to access health services. The aim of this systematic mapping review was to bring together published research from urgent and emergency care settings to identify drivers that underpin patient decisions to access urgent and emergency care. METHODS: Systematic searches were conducted across Medline (via Ovid SP), EMBASE (via Ovid), The Cochrane Library (via Wiley Online Library), Web of Science (via the Web of Knowledge), and the Cumulative Index to Nursing

and Allied Health Literature (CINAHL; via EBSCOhost). Peer-reviewed studies written in English that reported reasons for accessing or choosing emergency or urgent care services and were published between 1995 and 2016 were included. Data were extracted and reasons for choosing emergency and urgent care were identified and mapped. Thematic analysis was used to identify themes and findings were reported qualitatively using framework-based narrative synthesis. RESULTS: Thirty-eight studies were identified that met the inclusion criteria. Most studies were set in the United Kingdom (39.4%) or the United States (34.2%) and reported results relating to ED (68.4%). Thirty-nine percent of studies utilized qualitative or mixed research designs. Our thematic analysis identified six broad themes that summarized reasons why patients chose to access ED or urgent care. These were access to and confidence in primary care; perceived urgency, anxiety, and the value of reassurance from emergency-based services; views of family, friends, or healthcare professionals; convenience (location, not having to make appointment, and opening hours); individual patient factors (e.g., cost); and perceived need for emergency medical services or hospital care, treatment, or investigations. CONCLUSIONS: We identified six distinct reasons explaining why patients choose to access emergency and urgent care services: limited access to or confidence in primary care; patient perceived urgency; convenience; views of family, friends, or other health professionals; and a belief that their condition required the resources and facilities offered by a particular healthcare provider. There is a need to examine demand from a whole system perspective to gain better understanding of demand for different parts of the emergency and urgent care system and the characteristics of patients within each sector.

Cowling, T. E., Majeed, A. et Harris, M. J. (2018). "Importance of accessibility and opening hours to overall patient experience of general practice: analysis of repeated cross-sectional data from a national patient survey." Br J Gen Pract 68(672) : e469-e477.

BACKGROUND: The UK government aims to improve the accessibility of general practices in England, particularly by extending opening hours in the evenings and at weekends. It is unclear how important these factors are to patients' overall experiences of general practice. AIM: To examine associations between overall experience of general practice and patient experience of making appointments and satisfaction with opening hours. DESIGN AND SETTING: Analysis of repeated cross-sectional data from the General Practice Patient Surveys conducted from 2011-2012 until 2013-2014. These covered 8289 general practice surgeries in England. METHOD: Data from a national survey conducted three times over consecutive years were analysed. The outcome measure was overall experience, rated on a five-level interval scale. Associations were estimated as standardised regression coefficients, adjusted for responder characteristics and clustering within practices using multilevel linear regression. RESULTS: In total, there were 2 912 535 responders from all practices in England (n = 8289). Experience of making appointments (beta 0.24, 95% confidence interval [CI] = 0.24 to 0.25) and satisfaction with opening hours (beta 0.15, 95% CI = 0.15 to 0.16) were modestly associated with overall experience. Overall experience was most strongly associated with GP interpersonal quality of care (beta 0.34, 95% CI = 0.34 to 0.35) and receptionist helpfulness was positively associated with overall experience (beta 0.16, 95% CI = 0.16 to 0.17). Other patient experience measures had minimal associations (beta</=0.06). Models explained >/=90% of variation in overall experience between practices. CONCLUSION: Patient experience of making appointments and satisfaction with opening hours were only modestly associated with overall experience. Policymakers in England should not assume that recent policies to improve access will result in large improvements in patients' overall experience of general practice.

Desborough, J., Forrest, L. et Parker, R. (2012). "Nurse-led primary healthcare walk-in centres: an integrative literature review." J Adv Nurs 68(2) : 248-263.

> AIMS: This paper is a report of an integrative review of the international literature examining established nurse-led primary healthcare walk-in centres and their outcomes to understand whether they are effective in improving access to primary health care. BACKGROUND: Reviews of nurse-led primary care walk-in centres have included centres staffed by family physicians and general practitioners. There is a paucity of evidence about walk-in centres staffed solely by nurses. DATA SOURCES: Studies were identified through an electronic search using the databases Medline, Cinahl and EBSCO from 1990 until July 2010. Papers were included if they examined walk-in centres providing nurse-led primary care for the general community. Only peer reviewed studies published in English were included. REVIEW METHODS: An integrative approach utilizing Bowling's checklist facilitated a systematic appraisal of studies in regard to clarity of aims, objectives, methods and appropriate analysis of data. RESULTS: Thirteen publications were categorized into five themes: 'users of walk-in centres', 'quality of care provided at walk-in centres', 'impact on other healthcare providers', 'perceptions of walk-in centres' and 'satisfaction with walk-in centres'. CONCLUSION: The possibility that walk-in centres create demand highlights the need for clearer evidence of the drivers of demand for health care in walk-in centres. Innovations in healthcare provision need to be matched with adaptation to nursing education to ensure an adequately prepared nursing workforce. Improvement in access to primary healthcare needs to be measured in terms of equity and the capacity this access has to fill identified gaps in primary healthcare provision in the community.

Fisher, R. F., Lasserson, D. et Hayward, G. (2016). "Out-of-hours primary care use at the end of life: a descriptive study." Br J Gen Pract 66(650) : e654-660.

> BACKGROUND: Out-of-hours (OOH) primary care services are integral to the care of patients at end of life. Little is known about the OOH service usage of patients with palliative care needs. AIM: To describe patterns of usage of patients presenting to an OOH service and coded as 'palliative'. DESIGN AND SETTING: A descriptive study of data from the Oxfordshire OOH service. METHOD: A database of all patient contacts with the Oxfordshire OOH service from a 4-year period (June 2010-August 2014) was used to extract demographic and service usage data for all contacts to which clinicians had applied a 'palliative' code. Observed differences in demographic features between palliative and non-palliative contacts were tested using logistic regression. RESULTS: Out of a total of 496 931 contacts, there were 6045 contacts coded palliative; those 'palliative' contacts provided care to 3760 patients. Patients contacting the OOH service with palliative care needs did so predominantly during weekend daytime periods, and over a third had more than one contact. Patients were predictably older than the average population, but contacts coded as 'palliative' were relatively less deprived than contacts to the OOH service for all causes, even after adjusting for age and sex. CONCLUSION: The current 'one-size-fits-most' model of OOH primary care may not allow for the specific needs of patients at the end of life. Wider analysis of palliative patient flow through urgent care services is needed to identify whether healthcare access at the end of life is inequitable, as well as the capacity requirements of a community-based service that can provide high-quality end-of-life care.

Foley, C., Droog, E., Boyce, M., et al. (2017). "Patient experience of different regional models of urgent and emergency care: a cross-sectional survey study." BMJ Open 7(3) : e013339.

OBJECTIVES: To compare user experiences of 8 regional urgent and emergency care systems in the Republic of Ireland, and explore potential avenues for improvement. DESIGN: A cross-sectional survey. SETTING: Several distinct models of urgent and emergency care operate in Ireland, as system reconfiguration has been implemented in some regions but not others. The Urgent Care System Questionnaire was used to explore service users' experiences with urgent and emergency care. Linear regression and logistic regression were used to detect regional variation in each of the 3 domains and overall ratings of care. PARTICIPANTS: A nationally representative sample (N=8002) of the general population was contacted by telephone, yielding 1205 participants who self-identified as having used urgent and emergency care services in the previous 3 months. MAIN OUTCOME MEASURES: Patient experience was assessed across 3 domains: entry into the system, progress through the system and patient convenience of the system. Participants were also asked to provide an overall rating of the care they received. RESULTS: Service users in Dublin North East gave lower ratings on the entry into the system scale than those in Dublin South (adjusted mean difference=-0.18; 95% CI -0.35 to -0.10; p=0.038). For overall ratings of care, service users in the Mid-West were less likely than those in Dublin North East to give an excellent rating (adjusted OR 0.57; 95% CI 0.35 to 0.92; p=0.022). Survey items relating to communication, and consideration of patients' needs were comparatively poorly rated. The use of public emergency departments and out-of-hours general practice care was associated with poorer patient experiences. CONCLUSIONS: No consistent relationship was found between the type of urgent and emergency care model in different regions and patient experience. Scale-level data may not offer a useful metric for exploring the impact of system-level service change.

Forman, J. H., Robinson, C. H. et Krein, S. L. (2019). "Striving toward team-based continuity: provision of same-day access and continuity in academic primary care clinics." BMC Health Serv Res 19(1) : 145.

BACKGROUND: An important goal of the patient-centered medical home is increasing timely access for urgent needs, while maintaining continuity. In academic primary care clinics, meeting this goal, along with training medical residents and associated professionals, is challenging. METHODS: The aim of this study was to understand how academic primary care clinics provide continuity to patients requesting same-day access and identify factors that may affect site-level success. We conducted qualitative interviews from December 2013-October 2014 with primary care leadership involved with residency programs at 19 Veterans Health Administration academically-affiliated medical centers. Interview recordings were transcribed verbatim. To analyze the data, we created comprehensive, structured transcript summaries for each site. Site summaries were then entered into NVivo 10 software and coded by main categories to facilitate within-case and cross-case analyses. Themes and patterns across sites were identified using matrix analysis. RESULTS: Interviewees found it challenging to provide continuity for same-day in-person visits. Most sites took a team-based approach to ensure continuity and provide coverage for same-day access, notably using NPs, PAs, and RNs in their coverage algorithms. Further, they reported several adaptations that increased multiple types of continuity for walk-in patients, urgent care between in-person visits, and follow-up care. While this study focused on longitudinal continuity, both by individual PCPs or by a team of professionals, informational continuity and continuity of supervision, as well as, to a lesser extent, relational and management continuity, were also addressed in our interviews. Finally, most interviewees reported clinic intention to provide patient-centered, team-based care and a robust educational experience for trainees, and endeavored to structure their clinics in ways that align these two missions. CONCLUSIONS: In

contending with the tension between providing continuity and educating new clinicians, clinics have re-conceptualized continuity as team-based, creating alternative strategies to same-day visits with a usual provider, coupled with communication strategies. Understanding the effect of these strategies on different types of continuity as well as patient experience and outcomes are key next steps in the further development and dissemination of effective models for improving continuity and the transition to team-based care in the academic clinic setting.

Fowler Davis, S. (2018). "Factors affecting decisions to extend access to primary care: results of a qualitative evaluation of general practitioners' views." J Clin Nurs 8(3) : e019084.

OBJECTIVES: To report general practitioners' (GPs') views and experiences of an Enhanced Primary Care programme (EPCP) funded as part of the Prime Minister's Challenge Fund (second wave) for England which aimed to extend patient access to primary care. SETTING: Primary care in Sheffield, England. PARTICIPANTS: Semi-structured interviews with a purposive sample of GPs working in 24 practices across the city. RESULTS: Four core themes were derived: GPs' receptivity to the aims of the EPCP, their capacity to support integrated care teams, their capacity to manage urgent care and the value of some new community-based schemes to enhance locality-based primary care. GPs were aware of the policy initiatives associated with out-of-hours access that aimed to reduce emergency department and hospital admissions. Due to limited capacity to respond to the programme, they selected elements that directly related to local patient demand and did not increase their own workload. CONCLUSIONS: The variation in practice engagement and capacity to manage changes in primary care services warrants a subtle and specialist approach to programme planning. The study makes the case for enhanced planning and organisational development with GPs as stakeholders within individual practices and groups. This would ensure that policy implementation is effective and sustained at local level. A failure to localise implementation may be associated with increased workloading in primary care without the sustained benefits to patients and the public. To enable GPs to become involved in systems transformation, further research is needed to identify the best methods to engage GPs in programme planning and evaluation.

Goodridge, D. et Stempien, J. (2019). "Understanding why older adults choose to seek non-urgent care in the emergency department: the patient's perspective." Cjem 21(2) : 243-248.

OBJECTIVES: Older adults make up a significant proportion of patients seeking care in the ED, with about 25% of these visits classified as "non-urgent." This study explored older adults' understandings, expectations of and self-reported reasons for seeking care and treatment provided in the ED. METHODS: This qualitative study involved semi-structured interviews with CTAS 4-5 patients conducted at randomly selected times and days during ED visits at three Saskatoon facilities in 2016. Thematic analysis was used to analyze interview data. RESULTS: 115 patients over age 65 years (mean age 79.1 years) were interviewed. While the majority had independently or with family made the decision to attend the ED, almost one-third of patients (31.6%) reported that they had been referred to the ED by general practitioners or specialists. Few respondents indicated the visit was the result of their general practitioner not being available. Most participants cited comprehensiveness and convenience of diagnostic and treatment services in a single location as the primary motivation for seeking treatment in the ED, which was especially important to those in poor health, without family supports, or with functional limitations, personal mobility and/or transportation challenges. Other common motivations were availability of after-hours care

and perceived higher quality care compared to primary care. CONCLUSIONS: Accessibility to comprehensive care, availability, quality of care and positive past experiences were key considerations for older adults seeking treatment of non-urgent concerns. Older adults will likely continue to use EDs for non-urgent medical care until trusted, "one-stop" settings that better addresses the needs of this population are more widely available.

Glasby, J., Littlechild, R., Le Mesutier, N., et al. (2016). Who knows best? Older people's contribution to understanding and preventing avoidable hospital admissions. Birmingham Health Services Management Centre
http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2016/who-knows-best.pdf

The authors of this report interviewed 104 older people, exploring their experiences of emergency admissions. The research focused on whether the older people felt it was appropriate to be admitted to hospital and whether they thought anything could have prevented their admission. The findings of this study confirm the belief that older people have an important role to play in helping understand the nature of emergency admissions and to devise appropriate responses to their rising numbers. The report concludes that ignoring this expertise could be detrimental to ensuring older people get the appropriate care they need

Green, J., McDowall, Z. et Potts, H. W. (2008). "Does Choose & Book fail to deliver the expected choice to patients? A survey of patients' experience of outpatient appointment booking." BMC Med Inform Decis Mak 8

BACKGROUND: Choose and Book is a central part of the UK Government patient choice agenda that seeks to provide patients with a choice over the time, date and place of their first outpatient appointment. This is done through the use of a computerised booking system. After a 2004 pilot study, Choose and Book was formally launched in January 2006. This is the first study of patient experience of Choose and Book since then. METHODS: A questionnaire survey of reported experience of choice over the time, data and place of appointment, carried out in a National Health Service hospital in London. 104 patients at their first outpatient appointment completed the questionnaire, consisting of a consecutive series of patients referred through Choose and Book and a sample referred through the conventional booking system. RESULTS: Among the Choose and Book patients, 66% (31/47; 95% CI 52 to 78%) reported not being given a choice of appointment date, 66% (31/47; 95% CI 52 to 78%) reported not being given a choice of appointment time, 86% (37/43; 95% CI 74 to 94%) reported being given a choice of fewer than four hospitals in total and 32% (15/47; 95% CI 20 to 46%) reported not being given any choice of hospital. CONCLUSION: In this study, patients did not experience the degree of choice that Choose and Book was designed to deliver.

Greenfield, G., Greenfield, G., Ignatowicz, A., et al. (2016). "Staff perceptions on patient motives for attending GP-led urgent care centres in London: a qualitative study." BMJ Open 6(1) : e007683.

OBJECTIVES: General practitioner (GP)-led urgent care centres were established to meet the growing demand for urgent care. Staff members working in such centres are central in influencing patients' choices about which services they use, but little is known about staff perceptions of patients' motives for attending urgent care. We hence aimed to explore their perceptions of patients' motives for attending such centres. DESIGN: A phenomenological,

qualitative study, including semistructured interviews. The interviews were analysed using thematic content analysis. SETTING: 2 GP-led urgent care centres in 2 academic hospitals in London. PARTICIPANTS: 15 staff members working at the centres including 8 GPs, 5 emergency nurse practitioners and 2 receptionists. RESULTS: We identified 4 main themes: 'Confusion about choices', 'As if increase of appetite had grown; By what it fed on', 'Overt reasons, covert motives' and 'A question of legitimacy'. The participants thought that the centres introduce convenient and fast access for patients. So convenient, that an increasing number of patients use them as a regular alternative to their community GP. The participants perceived that patients attend the centres because they are anxious about their symptoms and view them as serious, cannot get an appointment with their GP quickly and conveniently, are dissatisfied with the GP, or lack self-care skills. Staff members perceived some motives as legitimate (an acute health need and difficulties in getting an appointment), and others as less legitimate (convenience, minor illness, and seeking quicker access to hospital facilities). CONCLUSIONS: The participants perceived that patients attend urgent care centres because of the convenience of access relative to primary care, as well as sense of acuity and anxiety, lack self-care skills and other reasons. They perceived some motives as more legitimate than others. Attention to unmet needs in primary care can help in promoting balanced access to urgent care.

Imison, C., Poteliakhoff, E. et Thompson, J. (2012). Older people and emergency bed use. Exploring variation. Londres The King's Fund
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/older-people-and-emergency-bed-use-aug-2012.pdf

This paper explores factors that might be driving the significant variation in use of hospital beds by patients over 65 admitted as an emergency. It considers the contribution made by patient-based (demand-side) factors, hospital (supply-side) factors, the availability of community services and resources, and broader system relationships (how care systems and staff work together and relate to each other) in driving the observed variation in length of stay and rate of admission. Its conclusions are based on new analysis by The King?s Fund of Hospital Episode Statistics (HES) and local population -based data.

Knowles, E., O'Cathain, A. et Nicholl, J. (2012). "Patients' experiences and views of an emergency and urgent care system." Health Expect 15(1) : 78-86.

BACKGROUND: Surveys of patients' experiences and views of health care usually focus on single services. During an unexpected episode of ill health, patients may make contact with different services and therefore experience care within an emergency and urgent care system. We developed the Urgent Care System Questionnaire and used it to describe patients' experiences and views of an emergency and urgent care system in England. METHODS: A market research company used quota sampling and random digit dialling to undertake a telephone survey of 1000 members of the general population in July 2007. RESULTS: 15% (151/1000) of the population reported using the emergency and urgent care system in the previous 3 months. Two thirds of users (68%, 98/145) contacted more than one service for their most recent event, with a mean of 2.0 services per event. Users entered the system through a range of services: the majority contacted a daytime GP in the first instance (59%, 85/145), and 12% (18/145) contacted either a 999 emergency ambulance or an emergency department. Satisfaction with all aspects of care diminished when four or more services had been contacted. CONCLUSIONS: This is the first study to describe patients' experiences and views of the emergency and urgent care system. The majority of patients

experienced a system of care rather than single service care. There was an indication that longer pathways resulted in lower levels of patient satisfaction. Health care organisations can undertake similar surveys to identify problems with their system or to assess the impact of changes made to their system.

Kowalski, A., Yoshioka, K., Mancuso, A., et al. (2018). "Factors and Preferences in Patient Selection and Location of Care." Health Serv Res 37(4) : 311-316.

There are many factors that influence the decisions that patients make regarding where they receive care. Two hundred thirty-three patients were surveyed in the primary care setting to determine patient satisfaction and characteristics that led patients to seeking treatment at primary care offices, urgent care centers, or emergency rooms. Respondents rated quality of care highest at the primary care office (P < .001). Patients also demonstrated preference for in-person care compared with video conferencing or telephone visits (P < .001).

Kraaijvanger, N., Rijpsma, D., Willink, L., et al. (2017). "Why patients self-refer to the Emergency Department: A qualitative interview study." J Eval Clin Pract 23(3) : 593-598.

RATIONALE, AIMS, AND OBJECTIVES: There have been multiple studies investigating reasons for patients to self-refer to the Emergency Department (ED). The majority made use of questionnaires and excluded patients with urgent conditions. The goal of this qualitative study is to explore what motives patients have to self-refer to an ED, also including patients in urgent triage categories. METHODS: In a large teaching hospital in the Netherlands, a qualitative interview study focusing on reasons for self-referring to the ED was performed. Self-referred patients were included until no new reasons for attending the ED were found. Exclusion criteria were as follows: not mentally able to be interviewed or not speaking Dutch. Patients who were in need of urgent care were treated first, before being asked to participate. Interviews followed a predefined topic guide. Practicing cyclic analysis, the interview topic guide was modified during the inclusion period. Interviews were recorded on an audio recorder, transcribed verbatim, and anonymized. Two investigators independently coded the information and combined the codes into meaningful clusters. Subsequently, these were categorized into themes to build a framework of reasons for self-referral to the ED. Characteristic quotes were used to illustrate the acquired theoretical framework. RESULTS: Thirty self-referred patients were interviewed. Most of the participants were male (63%), with a mean age of 46 years. Two main themes emerged from the interviews that are pertinent to the patients' decisions to attend the ED: (1) health concerns and (2) practical issues. CONCLUSIONS: This study found that there are 2 clearly distinctive reasons for self-referral to the ED: health concerns or practical motives. Self-referral because of practical motives is probably most suitable for strategies that aim to reduce inappropriate ED visits.

Lecours, C., Pomey, M. P. et Tremblay, M. E. (2013). L'hospitalisation et la consultation d'un médecin à l'urgence d'un hôpital : regard sur l'expérience vécue par les Québécois
https://www.stat.gouv.qc.ca/statistiques/sante/services/generale/hospitalisation-urgence.pdf

Pour la première fois au Québec, une enquête vise à documenter certains aspects de la performance du système de santé, comme l'accessibilité, la continuité, l'efficacité, l'équité d'accès, la réactivité et la sécurité des services, à l'échelle provinciale, régionale et locale. Il s'agit de l'enquête québécoise sur l'expérience de soins, 2010-2011. Au total, 48 100 personnes ont participé à cette enquête. Ce quatrième volume établit le profil des personnes ayant été hospitalisées au cours des 12 mois précédant l'enquête ainsi que de celles ayant

consulté un médecin à l'urgence d'un hôpital selon diverses caractéristiques sociodémographiques et de santé. Basés sur la dernière expérience hospitalisation ou de consultation d'un médecin à l'urgence d'un hôpital, des résultats concernant les raisons d'hospitalisation ou de la consultation ainsi que les délais sont également rapportés. (résumé de l'éditeur).

Levaggi, R., Montefiori, M. et Persico, L. (2020). "Speeding up the clinical pathways by accessing emergency departments." The European Journal of Health Economics 21(1) : 37-44. https://doi.org/10.1007/s10198-019-01107-5

Inappropriate emergency admissions create overcrowding and may reduce the quality of emergency care. In Italy, overcrowding is further exacerbated by patients who use emergency admissions as a shortcut to avoid the general practitioner (GP) gateway. In this paper, we investigate access to emergency departments (EDs) by patients with non-severe medical conditions and their willingness to wait. Population data for ED accesses in Liguria (an Italian administrative region) in 2016 were used to estimate the number of strategic accesses and waiting time elasticities of low-severity patients. Our results show that the practice of using EDs to skip gatekeeping is a serious problem. The percentage of patients who engage in such practice vary from 8.7 to 9.9% of non-urgent patients; they generally prefer to access more specialized hospitals, especially during weekdays, when GPs are available, but hospitals run at full capacity. Strategic patients are usually much younger than average. From a policy point of view, our results show that long waits may discourage "genuine" patients rather than strategic ones. It is necessary to develop a system to improve access to patients mainly requiring specialist care, along with enhancing the management of diagnostic examinations through primary care.

Long, T., Genao, I. et Horwitz, L. I. (2013). "Reasons for readmission in an underserved high-risk population: a qualitative analysis of a series of inpatient interviews." BMJ Open 3(9) : e003212.

OBJECTIVE: To gather qualitative data to elucidate the reasons for readmissions in a high-risk population of underserved patients. DESIGN: We created an instrument with 27 open-ended questions based on current interventions. SETTING: Yale-New Haven Hospital. PATIENTS: Patients at the Yale Adult Primary Care Center (PCC). MEASUREMENTS: We conducted semi-structured qualitative interviews of patients who had four or more admissions in the previous 6 months and were currently readmitted to the hospital. RESULTS: We completed 17 interviews and identified themes relating to risk of readmission. We found that patients went directly to the emergency department (ED) when they experienced a change in health status without contacting their primary provider. Reasons for this included poor telephone or urgent care access and the belief that the PCC could not treat acute illness. Many patients could not name their primary provider. Conversely, every patient except one reported being able to obtain medications without undue financial burden, and every patient reported receiving adequate home care services. CONCLUSIONS: These high-risk patients were receiving the formal services that they needed, but were making the decision to go to the ED because of inadequate access to care and fragmented primary care relationships. Formal transitional care services are unlikely to be adequate in reducing readmissions without also addressing primary care access and continuity.

Marconi, G. P., Pham, P. K. et Nager, A. L. (2017). "Caregiver Expectations and Satisfaction of Urgent Care in a Pediatric Emergency Department." J Ambul Care Manage 40(3) : 214-219.

Health care delivery expectations that may affect patient and caregiver satisfaction are not clearly understood. This study examined caregiver expectations and satisfaction with urgent care in a pediatric emergency department. Of 201 caregivers surveyed, we found that caregivers have specific expectations regarding clinical care of their child in terms of radiographic imaging, blood testing, antibiotics, pain management, and subspecialty consultation. Caregivers were generally less dissatisfied with the actual care provided than the urgent care physicians expected.

Morton, S., Ignatowicz, A., Gnani, S., et al. (2016). "Describing team development within a novel GP-led urgent care centre model: a qualitative study." 6(6) : e010224.

OBJECTIVE: Urgent care centres (UCCs) co-located within an emergency department were developed to reduce the numbers of inappropriate emergency department admissions. Since then various UCC models have developed, including a novel general practitioner (GP)-led UCC that incorporates both GPs and emergency nurse practitioners (ENPs). Traditionally these two groups do not work alongside each other within an emergency setting. Although good teamwork is crucial to better patient outcomes, there is little within the literature about the development of a team consisting of different healthcare professionals in a novel healthcare setting. Our aim was therefore to describe staff members' perspectives of team development within the GP-led UCC model. DESIGN: Open-ended semistructured interviews, analysed using thematic content analysis. SETTING: GP-led urgent care centres in two academic teaching hospitals in London. PARTICIPANTS: 15 UCC staff members including six GPs, four ENPs, two receptionists and three managers. RESULTS: Overall participants were positive about the interprofessional team that had developed and recognised that this process had taken time. Hierarchy within the UCC setting has diminished with time, although some residual hierarchical beliefs do appear to remain. Staff appreciated interdisciplinary collaboration was likely to improve patient care. Eight key facilitating factors for the team were identified: appointment of leaders, perception of fair workload, education on roles/skill sets and development of these, shared professional understanding, interdisciplinary working, ED collaboration, clinical guidelines and social interactions. CONCLUSIONS: A strong interprofessional team has evolved within the GP-led UCCs over time, breaking down traditional professional divides. Future implementation of UCC models should pro-actively incorporate the eight facilitating factors identified from the outset, to enable effective teams to develop more quickly.

Mukamel, D. B. et Ladd, H. (2019). "Patients' preferences over care settings for minor illnesses and injuries." 54(4) : 827-838.

OBJECTIVES: To identify consumers' preferences over care settings, such as physicians' offices, emergency rooms (ERs), urgent care centers, retail clinics, and virtual physicians on smartphones, for minor illnesses. DATA SOURCES: A survey conducted between 9/27/16 and 12/7/16 emailed to all University of California, Irvine employees. STUDY DESIGN: Participants were presented with 10 clinical scenarios and asked to choose the setting in which they wanted to receive care. We estimated multinomial conditional logit regression models, conditioning the choice on out-of-pocket costs, wait time, travel time, and chooser characteristics. DATA COLLECTION: 5451 out of 21 037 employees responded. PRINCIPAL FINDINGS: Out-of-pocket costs and wait time had minimal impact on patient's preference for site of care. Choices were driven primarily by the clinical scenario and patient characteristics. For chronic conditions and children's well-visits, the doctor's office was the preferred choice by a strong majority, but for most acute conditions, either the ER (for high severity) or urgent

care clinics (for lower severity) were preferred to the office setting, particularly among younger patients and those with less education. CONCLUSIONS: Patients have several alternatives to traditional physicians' offices and ERs. The low impact of out-of-pocket costs suggests that insurers interested in encouraging increased utilization of alternatives would need to consider substantial changes to benefit structure.

Myers, J. B., Cox, J., Teague, S., et al. (2016). "Transitions of Care Model Inclusive of Unplanned Care Improves the Patient Experience." J Patient Exp 3(1) : 20-23.

A major emphasis in health care is creating an experience whereby patients receive the right care at the right time from the right provider in the right setting at the right cost. Over the past several decades, there has been considerable effort in the area of medical management, with prior authorization, gatekeeper utilization management regimens, and other techniques designed to guide patients and caregivers into desired treatment pathways. Alternatively, the concept of demand management may be employed to achieve these desired outcomes by giving patients meaningful, expanded choices beyond traditional acute-care settings. The implementation of a novel, patient-centered, unplanned care delivery model is described along with illustrative case studies.

Nicholl, J., Hoff, T. et Prout, K. (2019). "Comparing Retail Clinics With Other Sites of Care: A Systematic Review of Cost, Quality, and Patient Satisfaction." Emerg Med J 57(9) : 734-741.

BACKGROUND: Retail clinics, also referred to as walk-in or convenient care clinics, share common features such as a limited menu of primary care services, on-demand patient appointments, greater use of nonphysician providers such as nurse practitioners, and more convenient hours and access points for patients. OBJECTIVES: Given their rising popularity as an alternative primary care delivery site, it is important to examine retail clinics' impact on patient outcomes. This study's aim was to systematically review the extant literature on retail clinics in the United States with respect to 3 outcomes of interest: quality, cost, and patient satisfaction. RESEARCH DESIGN: A systematic search of 4 databases was done using Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines. Studies needed to be empirical, measure care in retail, walk-in, or convenient care clinic, and present quality, cost, and/or satisfaction findings. MEASURES: The majority of studies used commercial, administrative claims databases to procure patient outcome data (n=9). Nine of the 15 studies examined costs, 6 examined quality, and only 1 examined patient satisfaction. RESULTS: Overall, retail clinic care compares favorably with similar care in other settings in terms of lower costs, although the evidence on quality and patient satisfaction is minimal and less conclusive. CONCLUSIONS: Future research on retail clinic care requires more rigorous study designs, richer quality measures, inclusion of the patient experience in outcomes, less reliance on administrative claims data, and greater independence from industry stakeholders with interest in seeing the retail clinic model grow.

O'Cathain, A., Coleman, P. et Nicholl, J. (2008). "Characteristics of the emergency and urgent care system important to patients: a qualitative study." J Health Serv Res Policy 13 Suppl 2 : 19-25.

OBJECTIVES: To explore patients' views and experiences of the emergency and urgent care system to inform the development of a questionnaire for routine assessment of the system's performance from the patient perspective. METHODS: Qualitative research with people who had recently used the system: 47 people in eight focus groups and 13 individual interviews. RESULTS: Recurrent themes included characteristics of the system which are rarely

addressed in service-specific questionnaires, in particular, confusion over the most appropriate service to use for particular health problems, coordination between services and informational continuity across services. Other characteristics were identified which, although commonly included in service-specific questionnaires, could have system-level consequences. These included communication between health professionals and patients, and ease of access to services. For example, patients' perception of poor communication with one service could increase their subsequent use of other services in the system. Proactive behaviour from health professionals was an important system characteristic because it could allay patient anxiety by making patients feel that their concerns were being taken seriously and that staff could sort out problems such as feeling 'stuck in' or 'bounced around' the system. 'Candidacy', whereby eligibility for health care is jointly negotiated between the user and the service provider, was evident as an issue for patients across the social spectrum when seeking help urgently. CONCLUSIONS: Questionnaires designed to assess patients' views and experiences of emergency and urgent care should address system-level as well as service-specific issues in order to address the full range of patient concerns.

O'Cathain, A., Knowles, E. et Nicholl, J. (2011). "Measuring patients' experiences and views of the emergency and urgent care system: psychometric testing of the urgent care system questionnaire." BMJ Qual Saf 20(2) : 134-140.

BACKGROUND: Patients seeking emergency and urgent care tend to experience a system, making choices about which service to use and making use of a number of services within a healthcare episode. The aim was to psychometrically test the Urgent Care System Questionnaire (UCSQ) for the routine measurement of the patient perspective of the emergency and urgent care system. METHODS: The UCSQ was developed based on qualitative research with recent users of the system. It consisted of a screening question to identify recent users and questions on the patient experience of, and satisfaction with, their most recent event. The acceptability, validity and reliability of the UCSQ were tested in a postal survey of 900 members of the general population and a telephone survey of a quota sample of 1000 members of the general population. RESULTS: The response rate to the postal survey was 51% (457/893). In the telephone survey, 11604 calls were made to obtain a quota sample of 1014 people. These surveys identified 250 system users in the previous 3 months. A principal-components analysis identified three satisfaction components with good internal consistency (Cronbach alpha between 0.7 and 0.93): 'progress through the system' (10 items), 'entry into the system' (three items) and 'patient convenience' (five items). These components varied as expected by age and overall rating of the system. CONCLUSION: Preliminary testing suggests that the UCSQ has reasonable acceptability, validity and reliability. Further testing is required, particularly its responsiveness to changes in emergency and urgent care systems.

O'Cathain, A., Knowles, E., Turner, J., et al. (2016). "Variation in avoidable emergency admissions: multiple case studies of emergency and urgent care systems." J Health Serv Res Policy 21(1) : 5-14.

OBJECTIVE: To identify factors affecting variation in avoidable emergency admissions that are not usually identified in statistical regression. METHODS: As part of an ethnographic residual analysis, we compared six emergency and urgent care systems in England, interviewing 82 commissioners and providers of key emergency and urgent care services. RESULTS: There was variation between the six cases in how interviewees described three parts of their emergency and urgent care systems. First, interviewees' descriptions revealed variation in the availability of services before patients decided to attend emergency departments. Poor

availability of general practice out of hours services in some of the cases reportedly made attendance at emergency departments the easier option for patients. Second, there was variation in how interviewees described patients being dealt with during their emergency department visit in terms of availability of senior review by specialists and in coding practices when patients were at risk of breaching the NHS's 4-hour waiting time target. Third, there was variability in services described as facilitating discharge home from emergency departments. In some cases, emergency department staff described dealing with multiple agencies in multiple localities outside the hospital, making admission the easier option. In other cases, proactive multidisciplinary rapid assessment teams were described as available to avoid admissions. Perceptions of resources available out of hours and the extent of integration between different health services, and between health and social services, also differed by case. CONCLUSIONS: This comparative case study approach identified further factors that may affect avoidable emergency admissions. Initiatives to improve GP out of hours services, make coding more accurately reflect patient experience, increase senior review in emergency departments, offer proactive multidisciplinary admission avoidance teams, improve the availability of out of hours care in the wider emergency and urgent care system, and increase service integration may reduce avoidable admissions. Evaluation of such initiatives would be necessary before wide-scale adoption.

Olsson, M. et Hansagi, H. (2001). "Repeated use of the emergency department: qualitative study of the patient's perspective." Emerg Med J 18(6) : 430-434.

OBJECTIVE: To explore what lies behind repeated emergency department (ED) use, from the patients' own perspectives. METHODS: Qualitative study based on in depth interviews with frequent users of the ED at the Huddinge University Hospital, Sweden. Ten adult patients having visited the ED 6-17 times in the previous 12 months were interviewed. The personal meaning they attached to the symptoms and their encounters at the ED were inductively analysed, thereby relating patient behaviour to life conditions. RESULTS: The frequent ED visitors perceive pain or other symptoms as a threat to life or to personal autonomy. Irrespective of whether or not the patients relate their health problems to a traumatic event, overwhelming anxiety compels them to seek urgent help. Clear cut diagnoses are seldom mentioned. Although none of the patients is homeless or totally lacking in means, the narratives reveal struggles with adverse life circumstances and medical, psychological and/or social problems, including alcohol or other substance misuse. Occasional referrals from the ED to a psychiatrist seem not to lead to any continuous treatment or to a change in the patients' health seeking behaviour. Satisfaction with care becomes adversely affected when the patients perceive that the ED staff classifies their use of the ED as inappropriate or when their symptoms are belittled. CONCLUSIONS: From their own perspectives, frequent ED visitors are in need of urgent care. It is particularly important to these patients that the personal meaning they attach to their symptoms is attended to and respected by the ED staff.

Panattoni, L., Stone, A., Chung, S., et al. (2015). "Patients report better satisfaction with part-time primary care physicians, despite less continuity of care and access." J Gen Intern Med 30(3) : 327-333.

BACKGROUND: The growing number of primary care physicians (PCPs) reducing their clinical work hours has raised concerns about meeting the future demand for services and fulfilling the continuity and access mandates for patient-centered care. However, the patient's experience of care with part-time physicians is relatively unknown, and may be mediated by

continuity and access to care outcomes. OBJECTIVE: We aimed to examine the relationships between a physicians' clinical full-time equivalent (FTE), continuity of care, access to care, and patient satisfaction with the physician. DESIGN: We used a multi-level structural equation estimation, with continuity and access modeled as mediators, for a cross-section in 2010. PARTICIPANTS: The study included family medicine (n = 104) and internal medicine (n = 101) physicians in a multi-specialty group practice, along with their patient satisfaction survey responses (n = 12,688). MAIN MEASURES: Physician level FTE, continuity of care received by patients, continuity of care provided by physician, and a Press Ganey patient satisfaction with the physician score, on a 0-100 % scale, were measured. Access to care was measured as days to the third next-available appointment. KEY RESULTS: Physician FTE was directly associated with better continuity of care received (0.172% per FTE, $p < 0.001$), better continuity of care provided (0.108% per FTE, $p < 0.001$), and better access to care (-0.033 days per FTE, $p < 0.01$), but worse patient satisfaction scores (-0.080% per FTE, $p = 0.03$). The continuity of care provided was a significant mediator (0.016% per FTE, $p < 0.01$) of the relationship between FTE and patient satisfaction; but overall, reduced clinical work hours were associated with better patient satisfaction (-0.053 % per FTE, $p = 0.03$). CONCLUSIONS: These results suggest that PCPs who choose to work fewer clinical hours may have worse continuity and access, but they may provide a better patient experience. Physician workforce planning should consider these care attributes when considering the role of part-time PCPs in practice redesign efforts and initiatives to meet the demand for primary care services.

Pope, C., Halford, S., Turnbull, J., et al. (2013). "Using computer decision support systems in NHS emergency and urgent care: ethnographic study using normalisation process theory." BMC Health Serv Res 13 : 111.

BACKGROUND: Information and communication technologies (ICTs) are often proposed as 'technological fixes' for problems facing healthcare. They promise to deliver services more quickly and cheaply. Yet research on the implementation of ICTs reveals a litany of delays, compromises and failures. Case studies have established that these technologies are difficult to embed in everyday healthcare. METHODS: We undertook an ethnographic comparative analysis of a single computer decision support system in three different settings to understand the implementation and everyday use of this technology which is designed to deal with calls to emergency and urgent care services. We examined the deployment of this technology in an established 999 ambulance call-handling service, a new single point of access for urgent care and an established general practice out-of-hours service. We used Normalization Process Theory as a framework to enable systematic cross-case analysis. RESULTS: Our data comprise nearly 500 hours of observation, interviews with 64 call-handlers, and stakeholders and documents about the technology and settings. The technology has been implemented and is used distinctively in each setting reflecting important differences between work and contexts. Using Normalisation Process Theory we show how the work (collective action) of implementing the system and maintaining its routine use was enabled by a range of actors who established coherence for the technology, secured buy-in (cognitive participation) and engaged in on-going appraisal and adjustment (reflexive monitoring). CONCLUSIONS: Huge effort was expended and continues to be required to implement and keep this technology in use. This innovation must be understood both as a computer technology and as a set of practices related to that technology, kept in place by a network of actors in particular contexts. While technologies can be 'made to work' in different settings, successful implementation has been achieved, and will only be maintained, through the efforts of those involved in the specific settings and if the wider context continues to support the coherence, cognitive participation, and reflective

monitoring processes that surround this collective action. Implementation is more than simply putting technologies in place - it requires new resources and considerable effort, perhaps on an on-going basis.

Pope, C., Prichard, J., McKenna, G., et al. (2019). "Deciding whether to consult the GP or an emergency department: A qualitative study of patient reasoning in Switzerland." BMC Health Serv Res 25(3) : 136-142.

Background: Non-urgent care is an important factor responsible for rising healthcare costs and general practitioners (GPs) are known to be more cost-effective than emergency departments (EDs). Objectives: To understand the reasons why patients confronted with a medical problem perceived as urgent choose to consult either a GP or an ED. Methods: We conducted a qualitative study in Switzerland, using data collected between 2014 and 2015 through semi-structured interviews of adults with non-vital medical problems. Half were recruited after an ambulatory consultation in an ED, and half were patients who consulted their GP. The audio-recorded interviews were transcribed, coded, and analysed according to the constant comparative method. Results: The main reason given by patients who consulted their GP first was the quality of the relationship. The more meaningful the relationship, the more likely patients were to seek advice from their GP. One marker of a privileged relationship was GPs supplying their mobile phone number to the patient. The perceived nature of the complaint, for example, symptoms considered as life-threatening or severe pain, together with the expected waiting time in an ED were additional factors influencing the patients' choice. Conclusion: Our study showed that when patients are confronted with what they perceive as a medical emergency, the quality of the relationship with the GP, in particular the continuity of care provided, seem to be the major reasons why they consult their GP rather than an ED.

Puig-Junoy, J., Saez, M. et Martinez-Garcia, E. (1998). "Why do patients prefer hospital emergency visits ? A nested multinomial logit analysis for patient-initiated contacts." Health Care Management Science 1 : 39-52, 39 tabl.

This paper analyzes the nature of health care provider choice in the case of patient-initiated contacts, with special reference to a National Health Service setting, where monetary prices are zero and general practitioners act as gatekeepers to publicly financed specialized care. We focus our attention on the factors that may explain the continuously increasing use of hospital emergency visits as opposed to other provider alternatives. An extended version of a discrete choice model of demand for patient-initiated contacts is presented, allowing for individual and town residence size differences in perceived quality (preferences) between alternative providers and including travel and waiting time as non-monetary costs. Results of a nested multinomial logit model of provider choice are presented. Individual choice between alternatives considers, in a repeated nested structure, self-care, primary care, hospital and clinic emergency services. Welfare implications and income effects are analyzed by computing compensating variations, and by simulating the effects of user fees by levels of income. Results indicate that compensating variation per visit is higher than the direct marginal cost of emergency visits, and consequently, emergency visits do not appear as an inefficient alternative even for non-urgent conditions.

Ryan, K. et Rahman, A. (2012). "Examining factors influencing patient satisfaction with nurse practitioners in rural urgent care centers." J Am Acad Nurse Pract 24(2) : 77-81.

PURPOSE: To examine if demographic factors influence patients' self reports of satisfaction with care provided by nurse practitioners (NPs) in rural urgent care centers (UCCs). DATA SOURCES: Data were collected between December 2009 and February 2010 using an 18-item self-report survey from a convenience sample of 53 patients in two rural UCCs. CONCLUSIONS: No statistical significance was noted in regards to patient satisfaction for the demographic factors age, gender, country of upbringing, or education level. Presence of health insurance was a significant factor, with uninsured patients rating higher levels of satisfaction. However, based on patients' responses to role clarity for this survey, it is evident that there continues to be insufficient public understanding of the role of NPs. IMPLICATIONS FOR PRACTICE: The future of the NP relies on patient approval as well as acceptance of the role. This study joins the pioneering efforts towards describing what patient satisfaction is and supports NPs serving as providers in rural, nonprimary care venues. By identifying influential factors of satisfaction, NPs can bridge the gap between availability of quality care versus a lack of access and inform policy changes in the future.

Saluja, S., McCormick, D., Cousineau, M. R., et al. (2019). "Barriers to Primary Care After the Affordable Care Act: A Qualitative Study of Los Angeles Safety-Net Patients' Experiences." Health Equity 3(1) : 423-430.

Purpose: Millions of people gained health care coverage in Los Angeles after the Affordable Care Act (ACA); however, challenges with obtaining and utilizing primary care still persist, particularly in the safety net. In this study, we explore barriers to accessing primary care services among safety-net patients in Los Angeles after Medicaid expansion and implementation of other programs for safety-net patients after the ACA. Methods: We conducted qualitative interviews, in Spanish and English, with 34 nonelderly adult patients in 1 of 3 insurance groups: Medicaid, MyHealthLA (a health care program for low-income undocumented individuals), or uninsured. We recruited participants from three sites in Los Angeles in 2017. We analyzed our interviews using a framework approach and included emerging concepts from participant responses. Results: We identified seven themes regarding barriers to accessing primary care: understanding the concept of primary care, finding a primary care provider (PCP), switching PCPs, getting timely appointments, geography and transportation, perceived cost or coverage barriers, and preferring emergency or urgent care over primary care. Patients with Medicaid were more likely to report barriers compared with other groups. Uninsured patients were less likely to understand the concept of primary care. Patients with MyHealthLA noted getting timely appointments and cost of care to be significant barriers. Conclusion: Despite Medicaid and other coverage expansions for safety-net patients after the ACA, substantial barriers to accessing primary care persist. Addressing such barriers through the development of targeted interventions or broader policy solutions could improve access to primary care for safety-net patients in Los Angeles.

Simon-Gozalbo, A., Llorente Parrado, C., Diaz Redondo, A., et al. (2020). "[Perceived quality of care by frequent paediatric healthcare users: A qualitative approach]." Emerg Med J 35(1) : 19-26.

INTRODUCTION: Assessing the perceived quality of a healthcare department by its users is essential in a quality management system. In Paediatric Emergency Departments (PED), the demand for urgent care has increased in recent years, as well as an increase in frequent attendance. Paying attention to the opinions of these habitual users by means of qualitative methodology is particularly suitable for assessing the quality of care and identifying opportunities to improve the PED. METHODS: Two focus groups were held with parents of

patients (with and without a chronic disease) who visited the PED on 10or more occasions per year in a third level hospital. RESULTS: The participants were satisfied overall with the PED. The treatment received was very positively valued, and they never felt that they had received poorer care due to being frequent users. As main strengths, they also highlighted the professional expertise, the friendliness of staff, the quality of information given, the medication received on discharge from hospital, and the follow-up carried out by the PED. The major improvement opportunities identified included: the contagion risks, the lack of coordination between different levels of care, and the need to improve the inclusion of families in the health care process. CONCLUSIONS: Due to the contributions made by these parents, several improvement strategies have been introduced, such as the implementation of sharing information protocols in shift changes, professional training courses, the establishment of a liaison person between the PED and Primary Care, and a proposal to the Hospital Management Department to assess the identified needs.

Spencer, B., Pasche, O., Kaitelidou, D., et al. (2019). "Development and validation of measurement tools for user experience evaluation surveys in the public primary healthcare facilities in Greece: a mixed methods study." Eur J Gen Pract 20(1) : 49.

BACKGROUND: The public primary healthcare system in Greece has not been fully developed and is delivered by urban and rural health centers, outpatient departments in public hospitals and the recently established first-contact and decentralized local primary care units. The aim of this study was to develop a valid and reliable measurement tool for conducting periodic user experience evaluation surveys in public Primary HealthCare facilities in Greece such as outpatient clinics of public hospitals and health centers. METHODS: A mixed methods approach was applied. In particular, the methodology of developing and validating the tools included three steps: (a) establishment of the theoretical background/literature review, (b) qualitative study: development of the tools items and establishment of the face validity and (c) quantitative study: pilot testing and establishment of the structural validity and estimation of the internal consistency of the tools. Two patient focus groups participated in qualitative study: one visiting health centres and the other visiting the outpatient clinics of public hospitals. Quantitative study included 733 Primary Health Care services' users/patients and was conducted during August-October 2017. Exploratory and confirmatory factor analysis was performed to check for structural validity of the tools, while Cronbach's alpha coefficients were estimated to check for reliability. RESULTS: Confirmatory factor analysis confirmed almost perfectly the presumed theoretical model and the following six factors were identified through the tools: (a) accessibility (three items, e.g. opening hours), (b) continuity and coordination of care (three items, e.g. doctor asks for medical history), (c) comprehensiveness of care (three items, e.g. doctor provides advices for healthy life), (d) quality of medical care (four items, e.g. sufficient examination time), (e) facility (four items, e.g. comfortable waiting room) and (f) quality of care provided by nurses and other health professionals (four items, e.g. polite nurses). CONCLUSIONS: We have developed reliable and valid tools to measure users' experiences in public Primary HealthCare facilities in Greece. These tools could be very useful in examining differences between different types of public Primary Health Care facilities and different populations.

Ssendikaddiwa, J. et Lavergne, R. (2019). "Access to Primary Care and Internet Searches for Walk-In Clinics and Emergency Departments in Canada: Observational Study Using Google Trends and Population Health Survey Data." 5(4) : e13130.

BACKGROUND: Access to primary care is a challenge for many Canadians. Models of primary care vary widely among provinces, including arrangements for same-day and after-hours access. Use of walk-in clinics and emergency departments (EDs) may also vary, but data sources that allow comparison are limited. OBJECTIVE: We used Google Trends to examine the relative frequency of searches for walk-in clinics and EDs across provinces and over time in Canada. We correlated provincial relative search frequencies from Google Trends with survey responses about primary care access from the Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries and the 2016 Canadian Community Health Survey. METHODS: We developed search strategies to capture the range of terms used for walk-in clinics (eg, urgent care clinic and after-hours clinic) and EDs (eg, emergency room) across Canadian provinces. We used Google Trends to determine the frequencies of these terms relative to total search volume within each province from January 2011 to December 2018. We calculated correlation coefficients and 95% CIs between provincial Google Trends relative search frequencies and survey responses. RESULTS: Relative search frequency of walk-in clinic searches increased steadily, doubling in most provinces between 2011 and 2018. Relative frequency of walk-in clinic searches was highest in the western provinces of British Columbia, Alberta, Saskatchewan, and Manitoba. At the provincial level, higher walk-in clinic relative search frequency was strongly positively correlated with the percentage of survey respondents who reported being able to get same- or next-day appointments to see a doctor or a nurse and inversely correlated with the percentage of respondents who reported going to ED for a condition that they thought could have been treated by providers at usual place of care. Relative search frequency for walk-in clinics was also inversely correlated with the percentage of respondents who reported having a regular medical provider. ED relative search frequencies were more stable over time, and we did not observe statistically significant correlation with survey data. CONCLUSIONS: Higher relative search frequency for walk-in clinics was positively correlated with the ability to get a same- or next-day appointment and inversely correlated with ED use for conditions treatable in the patient's regular place of care and also with having a regular medical provider. Findings suggest that patient use of Web-based tools to search for more convenient or accessible care through walk-in clinics is increasing over time. Further research is needed to validate Google Trends data with administrative information on service use.

Turnbull, J. (2019). "A conceptual model of urgent care sense-making and help-seeking: a qualitative interview study of urgent care users in England." J Clin Nurs 19(1) : 481.

BACKGROUND: Theoretical models have sought to comprehend and conceptualise how people seek help from health professionals but it is unclear if such models apply to urgent care. Much previous research does not explain the complex interactions that influence how people make sense of urgent care and how this shapes service use. This paper aims to conceptualise the complexity of sense-making and help-seeking behaviour in peoples' everyday evaluations of when and how to access modern urgent care provision. METHODS: This study comprised longitudinal semi-structured interviews undertaken in the South of England. We purposively sampled participants 75+, 18-26 years, and from East/Central Europe (sub-sample of 41 received a second interview at + 6-12 months). Framework analysis was thematic and comparative. RESULTS: The amount and nature of the effort (work) undertaken to make sense of urgent care was an overarching theme of the analysis. We distinguished three distinct types of work: illness work, moral work and navigation work. These take place at an individual level but are also shared or delegated across social networks and shaped by social context and time. We have developed a conceptual model that shows how people make sense of urgent care through work which then influences help-

seeking decisions and action. CONCLUSIONS: There are important intersections between individual work and their social networks, further shaped by social context and time, to influence help-seeking. Recognising different, hidden or additional work for some groups may help design and configure services to support patient work in understanding and navigating urgent care.

Van Leijen-Zeelenberg, J. E., Huismans, G. W., Bisschop, J. A., et al. (2016). "Experiences and preferences of patients visiting an otorhinolaryngology outpatient clinic: a qualitative study." Health Expect 19(2) : 275-287.

BACKGROUND: Patient-centred care has received considerable attention in the last few decades, but the patients' perspective remains underexposed. This study reports on an in-depth evaluation of patients' experiences and preferences at an otorhinolaryngology outpatient department. METHODS: Qualitative research was conducted on patients' experiences and preferences at an otorhinolaryngology outpatient department in an academic hospital. The study comprised two phases. First, semi-structured interviews were held with 22 patients. Second, results from the interviews were verified and deepened in a focus group (N = 7). RESULTS: Overall, experience with patient-centred care was positive at the outpatient department. Three of the six dimensions of patient-centred care predominated in the interviews and the focus group: information, communication and education; coordination and integration of care; and respect for patients' values, preferences and expressed needs. The negative experiences were mostly in these dimensions. The dimensions physical comfort and involvement of family and friends were of lesser significance. Opinion on emotional support--relieving fear and anxiety differed as to whether this was the responsibility of the doctor or the patient. CONCLUSION: Qualitative research provided a deeper understanding of patients' experiences and preferences at an otorhinolaryngology outpatient department. Such an in-depth evaluation can be useful in the transition towards patient-centred care.

Walls, C. A., Rhodes, K. V. et Kennedy, J. J. (2002). "The emergency department as usual source of medical care: estimates from the 1998 National Health Interview Survey." Academic Emergency Medicine 9(11) : 1140-1145.

Wardig, R. et Hadziabdic, E. (2019). "Healthcare staff's evaluation of a walk-in centre at a healthcare centre in an immigrant-dense area." 28(9-10) : 1473-1481.

AIMS AND OBJECTIVES: To evaluate a walk-in centre at a healthcare centre in an immigrant-dense area where a high proportion of the patients have limited language ability in Swedish, from the perspective of healthcare personnel. BACKGROUND: Increased global migration results in higher vulnerability in migrants, with the risk of increased morbidity and mortality. Migrants' health often deteriorates, which can be attributed to an increased level of stress and adaptation to a new lifestyle. Therefore, immigrants are at higher risk of being affected by, for example, cardiovascular diseases and diabetes. This requires access to good health care. DESIGN: A qualitative exploratory study was conducted, using semi-structured interviews. Content analysis was used in the analysis process. METHODS: Semi-structured interviews were held with 15 purposively sampled doctors and nurses, working at a healthcare centre in Sweden. Data were collected during autumn 2017. The study was performed in accordance with COREQ. RESULTS: Working at the walk-in centre involved caring for everything from basic to advanced health problems and meant a high pace that required stress-resistant personnel. The walk-in centre was described as both promoting and

threatening patient safety. The personnel had several ideas on how to develop the walk-in centre. CONCLUSIONS: A walk-in centre can be seen as a necessity related to issues of ensuring patient safety and delivering care for everyone in an immigrant-dense area. However, it cannot be the only form of care offered, as it seems not be adapted to certain groups, such as people with disabilities and the elderly. RELEVANCE TO CLINICAL PRACTICE: The findings emphasise that a walk-in centre is a way to increase accessibility for the entire population and offer equal care for all, even if it involves challenges that need to be addressed.

Wright, A. L. et Jack, S. M. (2019). "Indigenous mothers' experiences of using acute care health services for their infants." 28(21-22) : 3935-3948.

AIMS AND OBJECTIVES: To develop an understanding of how Indigenous mothers experience selecting and using health services for their infants can assist nurses in improving their access to care. This understanding may ultimately lead to improved health outcomes for Indigenous infants and their families. BACKGROUND: Access to acute care services is important to minimise morbidity and mortality from urgent health issues; however, Indigenous people describe difficulties accessing care. Indigenous infants are known to use the emergency department frequently, yet little is known about the facilitators and barriers their mothers experience when accessing these services. DESIGN: This study undertook a qualitative, interpretive description design. METHODS: This article adheres to the reporting guidelines of COREQ. Data collection methods included interviews and a discussion group with Indigenous mothers (n = 19). Data analysis was collaborative and incorporated both Indigenous and Western ways of knowing, through the application of Two-Eyed Seeing. RESULTS: A thematic summary resulted in six themes: (a) problematic wait times; (b) the hidden costs of acute care; (c) paediatric care; (d) trusting relationships; (e) racism and discrimination; and (f) holistic care. CONCLUSIONS: The experiences of Indigenous mothers using acute care services for their infants suggest a role for culturally safe and trauma and violence-informed care by health providers in the acute care context. RELEVANCE TO CLINICAL PRACTICE: Nurses can improve access to acute care services for Indigenous mothers and infants through the provision of culturally safe and trauma and violence-informed approaches care, by building rapport with families, providing care that is respectful and nonjudgemental, eliminating fees associated with using acute care services and linking families with cultural resources both in hospital and within the community.

Ressources électroniques

ORS (2020). Urgences et soins non programmés : dossier documentaire, Nantes : ORS ; Nantes : IRESP
https://ireps-ors-paysdelaloire.centredoc.fr/index.php?lvl=cmspage&pageid=6&id_rubrique=208#.Xr5S20BuKUm

Les soins non programmés sont entendus "comme ceux devant répondre à une urgence ressentie, mais ne relevant pas médicalement de l'urgence et ne nécessitant pas une prise en charge par les services hospitaliers d'accueil des urgences" (Rapport Mesnier 2018). Dans un contexte de demandes de soins non programmés croissantes (liées au vieillissement de la population, à l'augmentation de la prévalence des maladies chroniques et aux changements sociétaux, avec des usagers privilégiant les dispositifs perçus comme les plus réactifs devant un besoin de soin inopiné), d'une offre ambulatoire inégalement répartie, et de services

d'urgences hospitaliers engorgés... structurer les réponses à apporter dans les territoires est au cœur des enjeux actuels de transformation du système de santé (Stratégie "Ma santé 2022"). Cette sélection de ressources bibliographiques aborde cette thématique sous l'angle :
- des usagers du système de santé, et de leurs demandes de soins non programmés ;

ORS (2017). Fréquence des soins non programmés en médecine générale en France aux heures d'ouverture des cabinets de ville. Revue de littérature, Nantes : ORS
https://www.orspaysdelaloire.com/publications/frequence-des-soins-non-programmes-en-medecine-generale-en-france-aux-heures

Après une définition des soins non programmés, le champ de cette revue de littérature couvre une partie des recours urgents ou non programmés, à savoir les soins non programmés en médecine générale réalisés aux heures d'ouverture habituelles des cabinets, c'est-à-dire en dehors de celles de la permanence des soins. Cette revue de littérature exclut donc également les travaux portant sur les variations saisonnières (qu'il s'agisse de saisons touristiques ou périodes épidémiques).

Urgences médicales : comment prendre en charge des patients toujours plus nombreux ? Eclairage. Vie-publique.fr. 2020/02.
https://www.vie-publique.fr/eclairage/272843-urgences-medicales-comment-prendre-en-charge-des-patients-plus-nombreux#xtor=EPR-696